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SOCIAL WORK is a professional journal committed to improving practice and extending knowledge in the field of social welfare. The Editorial Board welcomes manuscripts that yield new insights into established practices, evaluate new techniques and researches, examine current social problems, or bring serious, critical analysis to bear on the problems of the profession itself. The occasional literary piece is gladly received when it concerns issues of significance to social workers.

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Guest Editor's Page

The issue of medical care for the aging and its financing by use of the social security mechanism has aroused such political passion that it has become a dominant social welfare frontier. It is sobering to realize how much individuals, groups, and professions may share a common goal—good will and decent care for the sick—and yet be so bitterly divided as to the means.

Social workers are less divided on this issue today than most other professions, a circumstance which sums up 30 years of change in the character of the profession. In the 1930's social workers were confused and divided about creating a permanent federal organization for social welfare. Today they rely with confidence upon a strong program of public and federally aided welfare services. The success of the social security program, Public Health Service, Office of Rehabilitation, and Children's Bureau constitutes a vote of confidence in the inherent strength of our democratic processes, in which the structure of government is used to meet people's needs without destroying either the people or their political system.

On the surface, the Congress will soon choose between an assistance approach and a social insurance approach to the health needs of the aging. In fact, the issue is whether we shall have a comprehensive program or a partial one. In the economic area, we have learned that a basic insurance for retirement (Old Age, Survivors, and Disability Insurance) requires a supplementary assistance program (Old Age Assistance) if individual variations in need are to be met. Health and medical care requires the same comprehensive approach. Social workers choose social insurance as the preferred method for a vigorous economy and independent citizenry; they support with equal confidence a decent medical assistance program, but as a supplement, not the sole means of dealing with urgent social problems.

The controversy over medical care is more than a reaffirmation of standard social work conviction. It has been an important opportunity to engage in constructive social action. Individual social workers helped develop the evidence for a new medical care program. One or two of them played a key role in President Kennedy's task force which framed realistic proposals for legislation. Countless others have helped shape public support by their advocacy in their own communities. Scores of voluntary social welfare agencies have joined the public controversy. The usual complaint that social workers are lost in the search for technique and status can hardly be less justified than today. What is more, social work has joined with many strong allies—church groups, labor unions, civic and citizen organizations.

When (and not if) medical care is brought into the social security program, a battle will have been won, but not the war against disease, distress, inequity, and insecurity in American life. All the professions concerned with the nation's health must somehow continue their joint efforts to provide excellent medical-social care. Doctors, nurses, and social workers constitute the basic team for this purpose. While their respective professional associations differ violently on the means, individual doctors and social workers continue to work intimately as a team. It is essential that their professional associations reinforce this individual co-operation when the dust of political conflict settles.

Once our public policy is fixed by the Congress, there remains the task of translating this policy into workable practice. Whatever the financing system for medical care, the scope of medical care must be extended and its quality protected; organization must be simple and effective; personnel must be adequate in numbers and skill. Above all, the new system must be tested to see what it can teach about the larger and still unanswered issue of medical care for the entire American people, not only the elderly. The next social policy issue for social work may well be adequate health service for the nation.

ROBERT MORRIS

BY WILLIAM B. TOLLEN

Financing Medical Care for the Aged

IN THIS DISCUSSION the following principles are accepted and recognized as valid:

1. Old people who need medical care should be able to receive such care in a manner that respects their dignity.

2. Free choice of physician is one of the basic rights to be respected in any system of medical care for the aged.

3. To the maximum extent possible, the cost of their medical care should be paid for by the aged themselves.

4. Methods of providing medical care for the aged that constitute or lead to "socialized medicine" are repugnant to most Americans.

If all or most of the aged had sufficient income or resources to pay for their medical care themselves, without depleting their means of providing for their ordinary living expenses, the subject of this discussion would hardly be of interest. The quality of medical care in this country is considered to be the finest in the world. No other nation exceeds us in wealth or standard of living. Nonetheless, there is fairly unanimous agreement that, for *some* of the aged, existing medical care systems are inadequate and must be supplemented. A major difference of opinion centers on the magitude of the "some."

How many of the aged are subsumed under this word?

One group believes that the problem of medical care for the aged has been exaggerated, and that "some" means only a minority. The majority of old people are believed to be financially capable of providing for their own medical care. An orderly evolution, building upon and improving existing voluntary health insurance and public programs for medical care of the needy aged, can solve the problem of the minority, in this view, without compulsion by government to which the majority of the aged should not be subjected.

Others believe that "some" means so many more than half as to warrant a nationwide extension of the federal social security program to include basic medical care for all the aged.

In his statement of May 4, 1960, before

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the House Ways and Means Committee, the then Secretary of Health, Education, and Welfare made these remarks concerning the number of the aged for whom existing medical care systems are inadequate. Our aged population of 16 million contains "an unusually large percentage of persons with very limited resources." A "large percentage of persons aged 65 and over do not have protection against long-term illnesses, and either cannot obtain protection at rates they can afford to pay, or cannot obtain adequate protection." There are "approximately 12 million persons 65 and over who have limited resources" and who need help to "enable them to cope with the heavy economic burden of long-term or other expensive illnesses."

What are the undisputed facts on which the interested citizen who subscribes to the four principles cited above can base his opinion? Few such "undisputed facts" are so recognized, namely:

1. There are approximately 16 million aged persons (65 years of age or older).

2. Twelve million aged persons have *incomes* of such nature and amount that they are not required to pay income taxes, including about 2 million who are recipients of public assistance.

3. Approximately 11 million aged persons are OASDI beneficiaries under the social security program whose OASDI benefits, plus any income they may earn from employment, do not exceed the limited maximums permissible to OASDI beneficiaries. Some of these aged persons have additional incomes from other sources, and some own liquid or other property resources.

4. The proportion of aged persons in our total population has been increasing and is expected to grow larger.

5. Medical care for the group of persons 65 years of age or older is more costly than medical care for the group under 65 years.

The following data related to the health status of the aged have been cited as conclusive by those holding one view, or dismissed as insignificant or "mere estimates" by those holding another view:

1. While long-term, chronic illness is found among all age groups, even among children, the proportion of aged persons with such illness is nearly twice the proportion for the total population generally (*Statistical Bulletin,* Metropolitan Life Insurance Company, August 1960, analyzing data obtained by the National Health Survey).

2. In 1958 the median income of aged males was $1,488 a year; 3 million aged persons were heads of families with annual income of less than $2,500 (Census Bureau data).

3. In 1959, at least 7.6 million aged persons had liquid assets of less than $500 (Federal Reserve Board consumer finance survey).

4. Based on a very low-cost food budget, an annual income of less than $2,560 for an aged couple is "uncomfortably low" (statement by the Secretary of Health, Education, and Welfare).

5. At the present time, about 6.5 million aged persons have some type of health insurance, and 9.5 million have none; by 1965, approximately 10 million aged persons are expected to have health insurance and 8 million are not (estimate of the Secretary of Health, Education, and Welfare).

Completely conclusive and current data concerning the financial status of the aged —their total income and the value of their property resources—are not at hand. Neither do we know accurately the extent to which their relatives are able and willing to help them in meeting their maintenance and medical needs. There are no comprehensive and valid statistical data on the feelings and beliefs of the aged themselves about dependence upon relatives, or government, for maintenance or medical care. We do not know whether the aged themselves would welcome or scorn a program of medical care financed through the federal social security system. We do not

know how many individual labor union members or individual physicians favor or oppose a social-security-based program of medical care for the aged, nor do we know how many are familiar with the data essential for an intelligent decision.

Controversy over methods of financing medical care for the aged has arisen, not because of differences as to the "undisputed facts" or even the partially disputed estimates, but because of differences in attitudes concerning matters far more fundamental. Attitudes toward the role of government in the daily lives of citizens in modern society and attitudes toward labor leaders and physicians have shaped opinions on medical care for the aged far more than the data on which the opinions are allegedly based.

The remedy urged by the officers of the American Medical Association is *voluntary health insurance supplemented by publicly financed medical care for the aged who are needy.* The solution offered by other equally prominent physicians is *health insurance financed through the social security system* (referred to by its opponents as "compulsory" health insurance) *and supplemented by privately financed medical care for the aged who prefer and can afford additional benefits.*

"Compulsory" health insurance (which, for all practical purposes, means medical care for the aged *based* on the social security program, embodying features of the Anderson, Gore, Forand, Humphrey, Kennedy, and McNamara bills introduced during the 86th Congress) has also been publicly advocated by officers of a number of labor unions and organizations. As has already been noted, we do not know how many individual workers, whose take-home pay would be reduced under an extension of social security to cover medical care, subscribe to this proposal. Similarly, we do not know the extent to which individual physicians agree with the stand taken by officers of their professional association, or the extent to which agreement or disagreement is based on informed evaluation of both alternatives.

Assuming that the data do not lead conclusively to either alternative, and recognizing that authorities on the subject differ, what direction is provided by considering the implications of the four principles enunciated at the outset of this discussion?

IMPLICATIONS OF THE FOUR PRINCIPLES

Old people who need medical care should be able to receive such care in a manner that respects their dignity. Extension of voluntary health insurance to provide adequate coverage would result in a system of medical care that did respect the dignity of the aged who could afford such insurance. A social-security-based system of medical care for the aged would also respect the dignity of the aged who could afford voluntary health insurance of adequate coverage. An aged person who is affluent enough to be able to afford such insurance would suffer no indignity in accepting social security medical benefits as a matter of right, because he has contributed to the cost. At least there is no evidence that any significant number of retired persons who are financially independent find it undignified to accept OASDI social security benefits under the existing system.

To provide for the aged who *cannot* afford voluntary health insurance of adequate coverage, various public programs have been advocated by those who oppose social-security-based medical care for the aged, and a new federal-state program of medical *assistance* for the aged has been established. The new program necessarily subjects the aged person to what is essentially a means test, however considerately and liberally it may be applied. Some of the programs may, and the few that have already been established do, involve an "investigation" of the income and needs of children to determine whether

they shall be required to meet the aged person's medical expenses before public aid is provided. If public assistance workers have learned anything at all during twenty-five years of the current federal-state program of Old Age Assistance, they have learned that most old people do not wish or like to be dependent upon their children, or upon the beneficence of government, or upon the charity of grocers, physicians, or anyone else. Gratitude has been mistaken for preference, where choice is nonexistent.

Both the system of voluntary health insurance supplemented by public programs for the aged who are needy, and the system of social-security-based medical care supplemented by voluntary health insurance for the aged who are interested, would equally respect the dignity of aged persons who can afford to pay for health insurance of adequate coverage. However, the latter system would respect the dignity of other aged persons to a degree that the former system could not equal.

Free choice of physician is one of the basic rights to be respected in any system of medical care for the aged. It is not, however, the only basic right, nor even the most important. Freedom to choose between filet mignon and porterhouse steak is of small moment for those who cannot afford bread. No right is absolute, and none is supreme above all others. The right to obtain medical care when needed, with dignity, is more fundamental than the right to free choice of physician. The right to free choice of physician is somewhat hollow for those who cannot afford to pay any physician. A principle must not become a fetish.

More significantly, there is nothing in a social-security-based system of medical care for the aged that constitutes a denial of the principle. This system would establish a method of *financing* payment for the costs of medical care. It would not limit choice by the patient any more than Blue Cross or Blue Shield. Voluntary health insurance establishes limits for the payments it makes for medical service; government health insurance would do no more. Both are based on the premise that the profession of medicine is more than a profit-making business with freedom to charge all that the traffic will bear. To the extent that this constitutes a denial of the principle of free choice of physician, both voluntary and government health insurance are equally reprehensible or virtuous.

To the maximum extent possible, the cost of their medical care should be paid for by the aged themselves. It is reasonably clear that, even if they should constitute less than a majority, the number of aged persons who are unable to pay the cost of voluntary health insurance of adequate coverage is fairly substantial. As taxpayers, like everyone else, these aged persons will have contributed to the cost of their medical care under public programs for the needy financed from general tax funds. In a very limited sense, therefore, they will have paid for their medical care themselves, although it will have been paid for to a far greater extent by those who do not directly benefit from public medical programs for the needy aged. Under a social-security-based system of medical care, the aged will have directly contributed to the cost of their medical care during all of their productive pre-retirement years. If it is our purpose to avoid "do-goodism" and to require individuals to pay for the services they request —if our approach is to be "business-like," with a keen concern for where the money is coming from—a social-security-based system of medical care for the aged would appear to be indicated.

Methods of providing medical care for the aged that constitute or lead to "socialized medicine" are repugnant to most Americans. Similarly, any measures that tend to promote communism, totalitarianism, the breakdown of the family, the destruction of American democracy, or incitement to revolution are objectionable.

The American Medical Association, the chief opponent of a social-security-based system of medical care for the aged, derives much of its opposition from the belief that such a system does constitute, or will inevitably lead to, "socialized medicine." Any nationwide program of medical care administered under governmental auspices can be more easily established and more effectively operated if the program is acceptable to, rather than opposed by, the American Medical Association. Admittedly, there is nothing in the training of physicians that qualifies them as experts in the financing of medical care. That training, thanks to organizations like the American Medical Association, is precise, vigorously scientific, with no toleration of fads or cultisms. Seven or eight long years in physics, chemistry, physiology, anatomy, and all the rest of the medical school curriculum have made of the American physician the trained, capable expert that he is —in diagnosis and treatment of human disease and disability and in identification of measures that promote physical and mental health; but not in the broad field of public welfare planning. But because in our hour of medical need we are so completely dependent upon the physician to take care of our most precious possession —ourselves—we tend to make of him a father-figure to whom we attribute insights beyond his capacities. Nonetheless, the physician is obviously the key figure in any system of medical care and the views of his professional association must receive the most careful consideration.

WILL IT LEAD TO SOCIALIZED MEDICINE?

How valid is the American Medical Association's judgment that a social-security-based system of medical care for the aged constitutes or leads to "socialized medicine"?

In 1930, the American Medical Association condemned the Sheppard-Towner Maternity and Infancy Act, which provided federal grants to aid states in reducing infant and maternal mortality, as "unsound in principle, wasteful and extravagant, unproductive of results and tending to promote communism," and urged adoption of other measures to reduce infant and maternal mortality (*Digest of Official Actions, 1846–1958,* American Medical Association, p. 92). The principal provisions of this act, which were incorporated in the Social Security Act, have been in effect for over twenty-five years. Clearly the AMA's judgment of the Sheppard-Towner act was unjustified and invalid. Its provisions have not tended to promote communism, nor have they proved wasteful, extravagant, or unproductive of results.

A report on the "Annual Conference of Secretaries of Constituent State Medical Societies," in a section headed "The Platform of the American Medical Association," published in the December 30, 1939, issue of the *Journal* of the AMA (p. 2428), contains the following judgment of social security programs: "Indeed, all forms of security, compulsory security, even against old-age and unemployment, represent a beginning invasion by the state into the personal life of the individual, represent a taking away of individual responsibility, a weakening of national caliber, a definite step toward either communism or totalitarianism." Today, twenty-one years later, it would be difficult to find any thoughtful critic of the social security program in general, or of the old age and unemployment insurance benefit provisions in particular, who seriously believes that these measures have brought this nation closer to communism or totalitarianism.

In December 1949, the Association opposed the social security disability benefits proposed in H.R. 6000 with the following judgment: "The program proposed in H.R. 6000 will adversely influence the patient's desire for recovery. Initiation of a compulsory federal disability program would represent another step toward na-

tionalization of medical care and socialization of the practice of medicine" (*Journal* of December 17, 1949, p. 1156). And yet the disability insurance provisions of the social security program have worked so well that at the last session of Congress the 50-year age limit was removed, without any increase in social security taxes and without any opposition from members of either political party.

Regulations of the U. S. Children's Bureau providing that diagnostic services for crippled children be made available without a means test were condemned by the Association in 1953 as "socialistic" (*Digest of Official Actions, 1846–1958,* p. 91). An interest in enabling impressionable children who are crippled to obtain needed health services without the embarrassment, if not humiliation, of subjecting their families to a means test can scarcely be dismissed as "socialistic."

Even voluntary health insurance, which the Association now regards as the solution to the problem of medical care for the aged, was regarded as "socialistic" by the American Medical Association when first advocated in this country during the 1930's. The reader is referred to the editorial entitled "The Committee on the Costs of Medical Care" in the AMA journal of December 3, 1932 (pp. 1950–1952) and the Association's analyses and comments on the Majority and Minority Reports of this committee (pp. 1954–1958). The Association urged complete rejection of the Majority Report, which had recommended group medical practice and voluntary health insurance, and supported instead the Minority Report. The Minority Report referred to "the evidence which can be produced to show that voluntary health insurance schemes have everywhere failed," stated that health insurance was "contrary to sound public policy" and had led to "destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession," and concluded that "the shortest road to commercialism of the practice of medicine is through the supposedly rosy path of insurance" (p. 1957).

The journal's editorial characterized the medical care systems proposed in the Majority Report as medical care rendered by "groups or guilds or medical soviets" (p. 1950). The Majority and Minority Reports, according to the journal, represent "the difference between incitement to revolution and a desire for gradual evolution based on analysis and study." The Majority Report was belittled as "representing the great foundations, public health officialdom, social theory—even socialism and communism—inciting to revolution" (p. 1951).

The Association, in *Bulletin 70,* published by its Bureau of Medical Economics Research, has defended its record on voluntary health insurance and has contended that while it opposed *bad* voluntary health insurance schemes, it "has never opposed voluntary sickness insurance plans in this country as they exist today." This allegation cannot be reconciled with the categorical and bitter denunciation of the Majority Report referred to above, nor is it in any sense validated by the Association's concession (in the journal editorial referred to) that voluntary health insurance for *major illlness or operation* "is foresighted, American, economical" (p. 1950). By very direct implication, the position of the editorial is that all other voluntary health insurance is shortsighted, un-American, and uneconomical.

Bulletin 70's quotations of official AMA statements on voluntary health insurance between 1916 and 1938 have been dismissed by the American Hospital Association with the statement: "Nowhere in the selected quotes is there a genuine word of encouragement to voluntary plans, much less a sign of leadership. There are words of caution, of criticism, of fear and warning. There are no words of confidence in the pioneers of voluntary sickness in-

surance, no words of faith in the principle of prepayment, and not even a forthright statement that some way must be found to make medical and hospital services more widely available. It is a sad fact that through the 1930's and early 1940's, the American Medical Association did not believe in voluntary sickness insurance, and did almost everything possible to prevent its development" (*Hospitals,* journal of the American Hospital Association, December 1949, p. 60).

Admittedly, the validity of one's present opinion is not affected by the fact that, in arriving at it, he has discarded notions previously advanced. The history of the American Medical Association's stand on broad questions of public policy concerning health and welfare problems reveals only that its judgment may have been unwarranted in the past, not that it is necessarily unsound as to similar issues today. However, most of the Association's present-day objections to social-security-based medical care for the aged are similar to the objections described in the preceding historical survey, and spring from the same fears and distrusts. Perhaps if physicians were not so preoccupied with technical medical problems and were more familiar with the dynamics of the social and economic problems of our time, their fears and distrusts (of "government," and of what they term government "interference" in medical affairs) could be allayed. As the Association's past stand on voluntary health insurance as well as various public health and welfare programs, based on these fears and distrusts, has proved unjustifiable, so their current stand on social-security-based medical care for the aged, based on the same fears and distrusts, appears no more valid.

Despite the development of our hospital system, the establishment of medical centers, the sharing of expensive medical equipment, and the co-operative interdisciplinary nature of modern medical treatment, the physician almost unavoidably sees the practice of medicine as essentially a one-to-one relationship. He wants no interference in that relationship, least of all by government. Perhaps greater exposure to and contact with health and welfare administrators who have made a career of public service, and greater familiarity with the human problems that are the concern of these administrators, can convince the physician that *a government-administered method of financing payment of medical care is not a limitation of the professional considerations that enter into medical treatment.*

It is manifestly impossible to determine, by scientific laboratory methods, whether social-security-based medical care for the aged constitutes or leads to "socialized medicine." Therefore, it may be urged that the American Medical Association pay some heed to *Business Week,* The *New York Times, Life Magazine,* Walter Lippman, Governor Nelson A. Rockefeller of New York, the governors of some thirty other states, and Marion B. Folsom (former Secretary of Health, Education, and Welfare in the Eisenhower administration, currently a director of Eastman Kodak Company), all of whom have concluded that a social-security-based system of medical care for the aged is the most effective method of meeting the present need; none of whom can seriously be suspected of any preference for socialism or communism; and none of whom is likely to be more deceived as to what leads to socialism or communism than the officers of the American Medical Association.

Some physicians, disagreeing with the opinion of officers of their professional association, have concluded that a social-security-based system of medical care for the aged is the most effective method of meeting the present and anticipated need. Among them are men of some stature in American medicine, for example, Dr. Basil McLean, former president of the national Blue Cross Association; Dr. James P. Dixon, commissioner of health, Philadel-

phia, 1952–1959, former member of the board of directors of the Hospital Council of Philadelphia; Dr. George Baehr, trustee (1950–1957) and president (1945–1949) of the New York Academy of Medicine, director of clinical research, Columbia University, 1944–1950; Dr. Allan M. Butler, professor of pediatrics, Harvard Medical School; and Dr. E. M. Bluestone, professor of hospital administration, Columbia and New York Universities.

MEANS TEST

There remains for consideration the Association's conviction that publicly administered medical programs for the aged should concern themselves only with the aged who are needy, or medically indigent, and must be based on a means test. Physicians are most familiar with the type of means test they themselves apply to some of their patients. This is at best an informal, almost casual, not too probing procedure, in which considerable weight is attached to the appearance and manner of the patient or of his relatives; at worst, a highly inaccurate and rather inequitable method of assessing degree of ability to pay.

Such a means test is a far cry from the procedure that any responsible public agency must follow, with its accountability to public auditors, legislative committees, and taxpayers in general. The public agency is expected or required by law to assure itself that only those who meet defined eligibility conditions receive the benefits of its program. It must request the applicant to specify in writing the nature and amount of his income and resources. It must require a sworn statement, with legal penalties for false representations, or conduct an investigation to verify the applicant's statements, or do both. The applicant is aware that his economic status will be measured against a standard; that the service he needs and has requested will be granted him only if that standard declares him needy or medically indigent; and that at least his economic life history will be entered upon a public record.

Implicit in the conviction of the American Medical Association that a publicly administered medical program for the aged should be concerned with and benefit only the needy, and therefore must be based on a means test, is the presumption (a) that submission to the means test is not or need not be humiliating; or (b) that if submission to the means test does offend the feelings of some old people, the number affected constitutes only a small minority; or (c) that their gratitude for the life-prolonging medical service freely provided outweighs any temporary embarrassment that may be experienced by aged beneficiaries of public medical programs obliged to undergo a means test. To make any of these assumptions is to misread the temper of the times. In a society in which material wealth is a mark of success, old people consider it offensive to be obliged to undergo a means test, particularly at a time when they and their families are already distressed by illness, because to them a means test represents a public confession of their failures and inadequacies. The aged prefer social security insurance benefits to public charity because acceptance of these benefits involves no social stigma. To dismiss the feelings of the aged themselves because the number adversely affected by a means test may be small, or because the time period during which their feelings are aggrieved is relatively short, is inconsistent with the objectives of an enlightened democracy. Moreover, it is doubtful that such an outlook will long be acceptable, since *there is an alternate method of financing medical care for the aged that respects the feelings of those who are in financial straits, without offending those who are not:* namely, a social-security-based system that respects the feelings of all.

The underlying attitude of the officers of the American Medical Association

toward a means test appears to reduce to the following: they have an antipathy to government-administered medical care that includes provisions for the aged who can afford to provide for their medical care themselves; they also have an interest in enabling the less affluent aged to receive medical care without a means test that offends dignity. But the antipathy is far greater than the interest. Only a willingness to understand the significance of a means test to the aged and an appreciation of *their* feelings when obliged to endure it can change this atttude of those who establish policy for the American Medical Association.

Government-administered medical care for the aged *only if* those who can afford to pay for their medical care are excluded; or government-administered medical care for the aged *even though* those who can afford to pay for their medical care are included—essentially, these are the alternatives. To accept the four principles enumerated at the beginning of this article, and to weigh objectively all the data relevant to this problem, is to follow the social security approach without hesitation. Voluntary health insurance and, *so long as may be necessary,* even public medical programs for the needy, should supplement a system in which the aged receive basic medical care as a matter of right, because they have contributed to the cost. Government alone can operate such a system with efficiency and equity. A government that is truly concerned with sustaining and prolonging the lives of its senior citizens and with promoting their health and well-being, in a manner that respects the dignity and feelings of *all* the aged, can do no less.

CLASS DIFFERENCES AND SOCIAL WORK'S TASK

BY MARTIN B. LOEB

I. Social Class and the American Social System

THE AMERICAN SOCIAL class system is so unique in Western civilization that it is even possible—though not plausible—to deny its existence. This uniqueness derives from the proportion of achieved status to ascribed status in the American social pattern, which is higher than in the historic European system—where the normal expectation has been that a person stayed in the social stratum to which he was born and in a sense liked it that way. One's expectations, at any rate, were more along the lines of "knowing one's place" than of moving to a different place, whether higher or lower. It is easy to overstate the stability of prewar European social structure, but there is little denying that the tendency toward an ascribed and rather rigid social status system was greater than in American society, to a degree sufficient for the difference to be a qualitative one.

The structure of American society has been described as an "open" social system. This means that, although social status is ascribed at birth as that of one's family, one may by changing one's values and behavior move from that status either up—which is preferable—or down, which is not totally disgraceful. Furthermore, there is achievement by whole social segments, readily exemplified by ethnic groups such as the Irish, Jews, or Italians. In the longer run, what can be seen as happening is that the distance between the top and bottom of our social system decreases—whole social classes move as well as individuals and families.

Even though there is this openness, and an emphasis on achievement rather than fixed labels, there are classes in America by which original status is ascribed and which provide goals for attainment.

Even those who would deny social class as an American phenomenon do not deny that there are many hierarchies in which an individual has his place: wealth; occupation; exclusiveness of organization, neighborhood, education; and so on. Argument arises around the point of whether positions on these hierarchies are highly correlated or of a correlation no more complex than the fact that position in any hierarchy is directly related to wealth.

In the past thirty to forty years there have been many studies showing the existence of layers in our society in which people share common sets of values.[1] In

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[1] *See* Allison Davis, Burleigh B. Gardner, and Mary R. Gardner, *Deep South* (Chicago: University of Chicago Press, 1941); August B. Hollingshead, *Elmtown's Youth* (New York: John Wiley & Sons, 1949); Robert S. Lynd and Helen M. Lynd, *Middletown* (New York: Harcourt, Brace and Company, 1929); Robert S. Lynd and Helen M.

each of these social classes the members tend to prize the same things and disapprove of the same things—and this like-and-dislike system includes liking people of higher social status and gratification at not being of lower status than one is. More important, however, is the fact that in each social class there is a sort of subculture—a way of life—in which there is a shared morality and a shared view of the macrocosm and the microcosm. It is social class as a way of life that makes it an important concept and tool for the humane professions. Value systems are the basis of communication, and unless one understands the value system one is dealing with, one cannot communicate very successfully.

There is another sense in which the existence of a social class system in the United States is denied. It may be said that, although there is status up and down, or from low to high, this is along a continuum rather than a set of layers allowing for such differentiation as upper-upper, lower-upper, upper-middle, lower-middle, upper-lower, and lower-lower. This perception of the American social system is easy to come by if one takes each of the many status-giving categories separately—such as education, occupation, and neighborhood. It is true that individuals or families can be found at any point along these continua, separately or together. However, one must keep in mind that there is a fairly large degree of social mobility, so that there are persons whose positions are in between whatever modalities can be found. And such modalities exist in every study this writer has seen of American communities.

This, however, is only the statistical analysis. A more qualitative approach yields more exactness, even though it is less rigorous. Using the status criteria or indices commonly used, isolating the modalities, and then studying the people with similar scores, we find that it is possible to describe differing life styles.[2] To describe a cultural approach to social class involves choosing categories that cut across the whole society to show the class differences. In a relatively recent study the writer has explored American class differences in the following categories: (1) family life, (2) use of leisure time, (3) work, (4) income, spending, and possessions, (5) church, (6) friendship patterns, (7) civic activities, clubs, and associations, (8) attitudes and activities concerning education.[3]

Life styles were differentiated for only five social classes, for in many communities the upper class is not only small, but there is not much differentiation between upper-upper and lower-upper. For large cities, however, it would be necessary to make this distinction.

Lynd, *Middletown in Transition* (New York: Harcourt, Brace and Company, 1937); W. Lloyd Warner and Paul S. Lunt, *The Social Life of a Modern Community*, "Yankee City Series," Vol. 1 (New Haven: Yale University Press, 1941); W. Lloyd Warner and Paul S. Lunt, *The Status System of a Modern Community*, "Yankee City Series," Vol. 2 (New Haven: Yale University Press, 1942); W. Lloyd Warner and Leo Srole, *The Systems of American Ethnic Groups*, "Yankee City Series," Vol. 3 (New Haven: Yale University Press, 1945); W. Lloyd Warner, Marchia Meeker, and Kenneth Eells, *Social Class in America* (Chicago: Science Research Associates, 1949); W. Lloyd Warner, with the collaboration of Wilfrid C. Bailey *et al.*, *Democracy in Jonesville* (New York: Harper & Brothers, 1949); James West, *Plainville, U.S.A.* (New York: Columbia University Press, 1945).

[2] *See* Jurgen Ruesch *et al.*, *Duodenal Ulcer, A Sociopsychological Study* (Berkeley, Calif.: University of California Press, 1948); Jurgen Ruesch *et al.*, *Chronic Disease and Psychological Invalidism* (Berkeley, Calif.: University of California Press, 1951); Jurgen Ruesch *et al.*, *Acculturation and Illness*, Psychological Monographs, Vol. 62, No. 5 (Washington, D. C.: American Psychological Association, 1948); W. Lloyd Warner, Robert J. Havighurst, and Martin B. Loeb, *Who Shall Be Educated? The Challenge of Unequal Opportunities* (New York: Harper & Brothers, 1941).

[3] This is based on a study of Kansas City, Missouri, part of the larger study of aging being carried on by the Committee on Human Development at the University of Chicago.

We do not have space for a detailed description of the life style of each social class, but a brief vignette may be illuminating, with a sentence or two for each of the categories mentioned.

UPPER CLASS

The family is a self-conscious clan with a name honored in the community and lived up to by the family members.

Leisure time is highly structured. The place where one spends it, and with whom, is as important as what one does.

A person works because others are dependent upon him for doing the right things and not particularly for the income.

Income, however, may be quite large, derived from investments. It is spent in ways that call for respect from oneself, the family, and the community.

Church membership is in a socially elite congregation which is traditional in the family. It supplies an arena for community leadership and an institution for such important rituals as christening, marriage, and death.

Friends for the upper-class person complement and support the social position primarily. Intimacy is confined to one or two relationships.

The upper class is involved in civic activities as a duty—it has to look after things.

Education is taken for granted, and the more established one is in the upper class, the more classical the education should be.

In summary: members of the upper class have a social position based on past generations—the nearest thing to an ascribed social position in the American social system. Its value system is modified more by the time perspective, past and future, than that of other social classes.

UPPER MIDDLE CLASS

The upper-middle-class family is characterized by the term "equalitarian." The husband-wife relationship is overtly complementary and children are provided with opportunities both social and financial. Kinfolk are recognized only if they fit the criteria for friends.

Leisure-time activities involve elaborate entertainment within and outside the home. There is a strong tendency to keep up with fads, and deep feeling for the notion of self-expression.

Work, on the other hand, is a way of life. Although earning a living is essential, being at work, being needed, and participating with one's fellows are equally important.

Income is derived largely from fees, salary, and profits. Spending is tastefully ostentatious. Labels are important; if the family must economize, it is done where it will show the least.

There are two variations of involvement in church:

1. There are those who are very active in church activities and regular attenders. They are very involved in church activity and may rationalize this in terms of the broader context of "This is what the community needs."

2. People who do not belong refuse to participate in church activities for intellectual reasons.

Friends complement oneself. They are more important than relatives because they are of one's own choosing. Freedom of choice and self-determination are important values in this class.

Its members belong to clubs and associations because they are helpful in business or to improve the family prestige.

They expect their children to have a college education in terms of an interesting experience as well as being economically advantageous.

LOWER MIDDLE CLASS

In the lower middle class, family is the means by which one belongs to the community. In it, each of the family roles is

well delineated and rules of family life are clearly and restrictively stated. There is a pride in the extended family and one might even tend to pick one's friends from one's relatives.

It is important to do something and to keep occupied in leisure time—preferably through physical activity.

Work is a way of making a living, and the job is the means and symbol of stability and security.

Income on these jobs tends to be steady and predictable. People buy lots of things —for space, like time, should have something it it.

They belong to and attend church regularly, and if questioned may justify this in terms of providing a model for their children. In general, they are rather unreflective about church participation—just feel it is "a good thing to do."

One chooses one's friends from among people one grows up with, works or has worked with, or among neighbors. Friends happen. In a sense they are given, like relatives, because of past common experiences. There is a tendency for friends to be friends as whole families and to act as family groups, going out together, picnicking, vacationing, and so on.

Interestingly enough, most lower-middle-class people are not joiners, except of a church, scouting, and maybe a fraternal organization like the Masons. On the other hand, when they are joiners they are compulsively so and join everything they can.

Education is a good thing because of its usefulness. It has a vocational aspect, an economic motivation. Every family wishes college for its children, which the parents say they "give" to them.

This lower middle class is in the writer's view the very core of the American class system. It is the top of the lower half and the starting place for the upper half. It is worth studying in some detail, for many welfare and educational efforts are concerned with helping lower-class people take on lower-middle-class values.

Another way of putting it would be to say that upper- and established upper-middle-class board members employ upper-middle-class professionals to help lower-class people become more like the lower middle class.

UPPER LOWER CLASS

There is an either/or aspect to the upper-lower-class family. The immediate family may be the focus for an extended family of aunts, uncles, cousins, grandparents, and so forth, if they are around at all. On the other hand, the family may be very much alone and isolated.

There is a great emphasis on masculinity for the husband, who is thought of as someone who ought to be strong and an economic provider. The wife is matriarchal, that is, she runs the home and in many activities treats the husband as a child to be looked after, indulged, and kept in line. The mother takes the same attitude toward her children, who are expected to be close and helpful. There is a tendency to discipline children with severe physical punishment when they are not in line.

The dichotomy of work and leisure is of a different nature here than in the higher classes. It is as if work interfered with being comfortable and comfort were physical in the sense that perhaps one would just like to sit.

The men may participate in activities such as sports and hunting as ways of acting out their masculine roles. Both men and women fish, go to the movies, and fill up time with TV. When not proving a sex role or working, the behavior could be characterized as passive, apathetic, or regressive.

The job is a way of earning money with which to live and acquire the necessities of life.

Income is derived from wages, and one has an uneasy feeling of security. That is, one can be laid off at any time, but unless this happens one feels secure. This leads

to a certain tentativeness. One buys what is needed immediately, or large movable items such as cars (large secondhand ones), refrigerators, television sets, and the like. In general, there has been little interest in where one lives or in living conditions. However, with the greater affluence of the society and with greater involvement in mass media, the women have become more interested in the home. Characteristically, they are particularly involved in improving kitchens.[4]

If one is a church member, one is very emotionally involved. Women are more likely to be involved than men. If, on the other hand, one is a church rejector, one is likely to be just as emotionally involved and to claim that the church takes advantage of people, just wants money, and so on.

People tend to say they have lots of friends, but that none are intimate. It is difficult to distinguish friends from relatives. For men, friends are "the guys I work with," and for a woman maybe one or two neighbors with whom she has a gossiping relationship.

Upper-lower-class members are not much interested in organizations or civic activities, other than some lodges, and most belong to unions without much participation.

They think it would be good if their children could go to college, under the general rubric that education is a good thing. However, immediate economic welfare is much more important, and all planning is done in terms of rather immediate economic sufficiency.

LOWER LOWER CLASS

There are really two lower lower classes: one, which I will discuss here, is made up of those at the bottom of the social heap, but with expectations—however vague—that life and their social prestige will get better. Then there are those who have fallen to the bottom, or who like it there. These "hard-core" types look the same, but there are differences in motivation.

In the lower lower class the family is a housekeeping unit and in general one of the parents, usually the mother, provides the basic continuity. The husband in such a case may seem to be a kind of male helper who may not even be seen as a provider. Children are members of the family unit to be fed, clothed, and housed until they are old enough to fend for themselves. If there is any extended family, it tends to break into groups, and one is intimate with some and not with others. As an adult relating to parents, there seems to be a childlike attachment or detachment.

There seems to be no real concept of leisure. Work is a burden, and *not work* is a burden, since it means one is not earning money. Simply staying alive is a major concern and keeps one pretty tired, either working or worrying about having no income.

A job means money for as long as you can hold it—that is, the job or the money.

Income is sporadic and from wages. People spend what they have, when they have it, on what they want immediately.

One gets involved in church activities in terms of a ritual behavior with a large emotional component. It may be the only overt emotional experience to be had. If one is not a church attender it is because one rejects the stability or has other ways of getting an emotional kick.

Friendship means acquaintanceship. Friends are people one works with, and the word "friend" is used for someone who helps you—such as one's employer or maybe the social worker. Intimacy is rare, and there is a considerable degree of distrust and suspicion.

These people have practically no con-

[4] *See* Lee Rainwater, Richard P. Coleman, and Gerald Handel, *Workingman's Wife* (New York: Oceana Publications, 1959), and Lee Rainwater assisted by Karol Kane Weinstein, *And the Poor Get Children* (Chicago: Quadrangle Books, 1960).

cept of self, in the role of a club member or citizen. They are wholly dependent upon others to do the decision-making.

Education is just one more burden. It is a demand to be avoided if and when possible.

CLASS TRANSITIONS

These short profiles of the five social classes discernible in most communities have been presented for two reasons:

1. To show that social classes exist in behavioral terms.

2. To demonstrate that it is possible to describe these subcultures or life styles in terms that can be helpful in health and welfare activities. To say that there are social class differences is not enough, nor is it enough to discuss discrimination based on class differences. What we must have is greater knowledge of the values and personalities of members of each social class. We need to know, too, what aspects of these value systems are most amenable to change, so that we may help those who wish it to achieve, not only higher social class prestige, but a better standard of living within American society.

Let us look at what is required to move into the middle class from the lower class. This is important for such problems as family planning. A basic theme in the middle class is that of delayed gratification —that is, substituting for present satisfaction a future gain, as in practicing the piano, learning Latin, or avoiding the joys of sexuality. A basic theme of the lower class is "short-run hedonism," or living for the present.

What professional people think of as rational, not to say common sense, is the ability to make choices for long-term benefits. Yet this lesson is perhaps the most difficult for lower-class people to learn. It might be said that it requires a personality change.

In addition to this basic change in outlook other changes are needed, in what is valued. To put it in rather extreme form, the middle-class family can and does choose between another baby and a new refrigerator. This very interest in the standard of living involves the belief that it is attainable. Here again the change in *Weltanschauung* from fatalism to self-determination is one of major significance.

Although it has been said that this is particularly a man's point of view, the fact is that to have much interest in child-bearing nine months hence while involved in the throes of sexual intercourse may be a very specially learned capacity rather than common sense. It involves a whole orientation to the future and faith in the efficacy of choice. Credit and instalment buying may increase the size of middle-class families by making them more present-time oriented. On the other hand, by involving lower-class people in the joys of a materialistic standard of living and in the notion of the possibility of attainment, families may be more readily limited in those classes. However, family limitation —greater involvement in family environment, combined with such expressions of self-determination as being willing to go long distances to birth control clinics and sit for long hours waiting in them—may be too much for many people to take in one acculturative gulp.

LIFE STYLE AS DETERMINING FACTOR

The American social class system is patterned on, but certainly not a copy of, the European system. The major difference between the two is that in America, by changing one's behavior and values, one may move from one class to another—either up or down. This social mobility appears as a distinct possibility to everyone. One moves from one way of life to another group, which one joins. It is characteristic of the American social system that behavior, not the individual per se, is given a social class rating. Although we

tend to ascribe moral, economic, intellectual, or psychological causes for the various social levels, it is more feasible to view them as variant cultural patterns or life styles that range from the least to most desirable—from lower classes through middle classes to upper classes.

These different life styles are really cultures derived from the social class structure. A social class may be defined as a ranked segment of society within which most of one's intimate participations take place. As people participate more with one another, they develop characteristic values and ways of living which provide communality and are taught to the young.

Many of our professional health and welfare tasks involve modifying lower-class values toward middle-class participation. The social agencies and their personnel, by understanding clearly both their own values and those of their clients, can communicate better and perform their functions more effectively.

BY GERALD HANDEL AND LEE RAINWATER

II. Working-Class People and Family Planning

SOCIAL WORK'S TASK is to deal with social problems. Dealing with any kind of problem today calls for new kinds of knowledge and perhaps even new attitudes.

There was a time when most social problems were dealt with in moral terms. Criminality, drunkenness, and poverty were regarded as the result of individual moral failure. The person who manifested such a condition was considered unworthy—someone to be ostracized, condemned, and punished. He was judged accountable for his own behavior, and therefore deserved not only the unhappy condition he got himself into but any punishment society meted out to him for violating social decency.

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While this attitude never vanished entirely, it was superseded by a new one which developed on the rising tide of science. Certainly by the end of the nineteenth century thoughtful people were beginning to look at human behavior with a scientific turn of mind, and in the first half of the twentieth century both social work and social science have regarded it more analytically than moralistically. It began to be apparent that the individual was not entirely responsible for behaving the way he did, whether he was a good citizen or a bad one. A person was increasingly seen as the product of his environment—a result of the kind of home, neighborhood, and community he came from. If he was decent, hard-working, responsible, and self-controlled, this was likely to be because he had enjoyed the advantages of loving parents with well-integrated personalities who provided him with a good home in decent physical sur-

roundings. If he got into trouble with the law or behaved irresponsibly toward himself or his wife and children, he was likely to have grown up in unfortunate circumstances, lacking love, or one parent, or a stable home, or decent housing and neighborhood. His deviant behavior was seen as due to causes essentially beyond his control, and what was called for was therefore sympathetic and skilled understanding rather than moral condemnation. This point of view has stimulated efforts in a variety of fields to blend sympathy and skill in order to achieve rehabilitation. Thus, we seek prison reform in order to facilitate the offender's re-entry into society after his sentence is completed. Unwed mothers are helped to become more stable persons rather than being simply stigmatized.

This effort to deal with social offenses both more humanely and more scientifically has not developed equally in all problem areas. To take just one example, the field of narcotics addiction remains a battleground of controversy between the legalistic-punitive approach and the medical-psychiatric-sociological approach. With other problems, too, the skillful-sympathetic approach represented by social work has met resistance. One reason for this is that many people believe it leads too easily to excusing the social offender, encouraging repetition of the behavior rather than curing or otherwise preventing it. Doubts of this kind are probably becoming increasingly widespread, so that it becomes increasingly difficult to be satisfied with blaming social conditions instead of the offender. The kind of teen-age gang killings that have frightened New York and Chicago makes it difficult for us to maintain the hopeful viewpoint of a generation ago that "there is no such thing as a bad boy."

We are caught in a dilemma. On the one hand, our understanding has advanced to the point where we can appreciate how an individual's life is shaped by forces greater than himself. On the other hand we are coming to feel increasingly that, regardless of what has caused the problem, the "problem person" must assume a measure of responsibility if the problem is to be solved. There are signs of society's growing impatience with certain kinds of social problems. Not long ago a Chicago judge made a statement from the bench, in a case involving a twenty-five-year-old unmarried mother whose four children died in a fire while she was out drinking, to the effect that the program of Aid to Dependent Children meant that the state was subsidizing illegitimacy. He was not quoted as suggesting that the program be discontinued, but his pronouncement reflects society's frustration at having to spend its resources on people who show so little capacity for assuming even a modicum of responsibility.

The task of social science and social work today is to find ways to integrate our understanding of human behavior and our sympathy with those who grow up and live in destructive circumstances with society's requirements of individual responsibility. We have somehow to integrate the two ideas: society's collective responsibility and the person's individual responsibility.

FAILURE TO STRIVE

In feudal times, individual responsibility pertained chiefly to the upper class. A noble was responsible for the welfare of the serfs who worked his domain and acknowledged his lordship. With the rise of entrepreneurial capitalism and the doctrine of individual salvation, the sense of individual responsibility has come to be centered in the middle class, and there it has largely remained. To run a business or practice a profession—the two historic ways in which middle-class people have earned their living—requires a sense of individual responsibility.

The greatest number of problem cases and the most severe problems requiring social work action tend to come from the working class, and particularly the lower

half of the working class. These cases are often the most difficult to deal with, and their problems the most resistant to solution. In the last analysis, this arises from the lower-class person's difficulty in assuming individual responsibility as the middle-class person understands it. How does this come about?

We have to look beyond the apparent, though not unimportant, factors of slum neighborhoods, dilapidated housing, poor education, and broken families. We have to look at the personalities of these people. We have to grasp how they perceive the world in which they live. The clinical worker is accustomed to thinking of personality as an individual matter—and so it is, up to a point. But a personality is formed in a social setting, and people who grow up in similar settings tend to have certain personality similarities. Most middle-class people, for example, strive to better themselves. What they strive for differs from person to person, as does the method of striving. But this basic motive of *striving for something* is a middle-class trait. The many complications engendered by striving are what bring many middle-class people into psychotherapy, treatment for psychosomatic disorders, and other kinds of remedial procedures.

In a general sense, the lower-class person comes to the attention of social agencies either because of his failure to strive sufficiently or because of his failure to strive in ways that are socially acceptable. We shall look at some examples of how this failure is expressed in certain specific problem areas, but first let us examine what underlies the failure itself.

Striving can only be sustained by a person who is able to assume that he lives in a world of at least a minimum degree of stability. He must believe that a certain orderliness prevails, so that if he directs himself toward certain goals in socially acceptable or prescribed ways, the social order will support his efforts by approving what he does and giving him appropriate rewards. Three distinct assumptions are necessary for this outlook:

1. That our own efforts can be effective.
2. That the world contains rewards which it will make available under appropriate conditions.
3. That the principal condition under which these rewards become available is the success of our own efforts.

The working-class person knows that there are rewards, but he has difficulty in believing that they have much connection with his efforts. To him the world is unpredictable, governed by such large and indeterminate forces as "luck," "fate," and "the will of God."[1] Sometimes these forces operate by themselves. Sometimes they operate through the agency of other people who are in control. Thus, if the breaks come your way you might get a good job. Or—more personally—if you are lucky enough to be liked by an employer, he might hire you. If your son gets into trouble, he might get a break if you're lucky enough to go before a lenient judge.

For a great many of these people there is very little sense of real order in the world. Things happen inexplicably. One can't predict what may happen, except that bad luck seems somewhat more likely than good luck. But what kind of bad luck it will be—this one cannot be sure of. One may be suddenly laid off from work, illness may strike, a child may get into trouble with the authorities.

For the lower-class person this unpredictability begins early in life. In the lower-class family the child is much more likely to be treated inconsistently than in the middle-class family. He may be alternately indulged and thwarted, with no clear connection to the child's own behavior. The parents' mood is the determining factor. Often there is no perception of the child as a being entitled to an

[1] Lee Rainwater, Richard P. Coleman, and Gerald Handel, *Workingman's Wife: Her Personality, World and Life Style* (New York: Oceana Publications, 1959).

integrity of his own. In this group, the goals of child-rearing are not to foster development of interests and talents so much as to keep children from being troublesome and from getting into trouble. The young child who asks questions may be simply ignored, or told to shut up, or slapped. Children's comments are often greeted with a mere "Shut up!"

Growing up in this kind of interpersonal milieu, the working-class person is likely to see the world as unloving as well as unpredictable. He learns to be wary of others. In addition, his upbringing provides him with few experiences or opportunities that enable him to learn how to make common cause with others. His ability to communicate emotionally is limited. He does not know how to form relationships in which there is give-and-take—in which one governs one's own behavior in part by anticipating what someone else—wife or child—would wish.

In a profound sense, the working-class person is likely to be passive. This does not mean lacking in physical energy. The physical labor that these people, both men and women, perform may be quite hard. But they are passive in their character. They are more likely to hope for something than to strive for it. They have usually not had the opportunity to identify with a person who strives. They have very little basis for believing that striving will bring reward. The unskilled or semiskilled worker is likely to be earning as much at age 25 as at age 45. He usually cannot look forward to increasing income based on increased experience, since it is unaccompanied by any real increase in skill.

The stance toward life is to see what comes from day to day. People at this level of life respond to presented stimulation much more than they take action toward some goal. They do not know what to do or how to do it in order to gain greater mastery over their own lives. Even while they may wish to do so, they are caught in a fundamental hopelessness.

They grow up, then, and reach adulthood with what we may characterize in psychological terms as ego limitations. Their capacity for organizing their own experience and putting it to their own self-determined use is limited. Their ability to plan is poor, not only because of their lack of hopefulness, but also because they have difficulty in inhibiting impulses of the moment. They want to do what they want to do—now. Characteristically, they deal with stress and unpleasantness by regressing to self-indulgent gratification. Thinking is a difficult activity for which they have little training or inclination. Their ability to communicate with each other is poor, so that their insight is limited, often very severely. This is a source of great frustration to the social worker who tries to work with them.

But what the social worker must realize he is up against in clients from the lower part of the working class is a deep sense of powerlessness. They do not come into the social work situation with a backlog of experience that problems can be solved by effort and through collaborative work with someone else. Their experience has eventuated, rather, in the conviction that what will be will be. And their principal resources in coping with life are fortitude and wishfulness. These are of value in dealing with difficulties after they occur, but of little use alone in actually solving the difficulties or preventing them from occurring again.

CHARACTERISTICS OF WORKING-CLASS MARRIAGE

How are these characteristics of working-class life and personality expressed in problems of concern to social agencies? Our organization, Social Research, Inc., has conducted a number of studies which have taught us something about the working-class family. One recent study of family planning in the working class, sponsored by the Planned Parenthood Federation of

America and directed by Dr. Rainwater, investigated the ways in which the working-class marriage affects family planning.[2] This study was concerned quite directly with attitudes toward sexuality and with contraceptive behavior as these related to the marital relationship in general. Family planning behavior is a sensitive indicator of many characteristics of the working class, exemplifying the attitudes we have described.

A working-class marriage tends to be rather different in character from a middle-class one. This may be illustrated by quoting from an interview in the study.

> "My husband and I don't talk too much [about family planning]. Sometimes he says we have too damn many and I say, 'yeah,' and that's that. I told him Mom was taking me to the doctor and I don't know what he thought about it. I brought the diaphragm home and showed it to him. It didn't work; I think I'm pregnant now. I used it some of the time but not that one night. I went to bed early and by the time I was enough awake to know what was happening it was all over. I asked him to stop; I told him I didn't have my diaphragm on, but he acted like he couldn't hear. My husband tried rubbers but he says he's too big and they hurt him real bad. [Who should have the main responsibility for contraception?] The wife. She has to have the kids, so she won't forget. The husband should help, though, by not doing anything without asking the wife about whether she's got it in."[3]

This lower-lower-class woman already has more children than she wants. She has been married four years and has three children spaced a year apart. She wants no more, is willing to take as much responsibility for birth control as she can; but if her husband will not co-operate at the minimum level she requests, she cannot achieve her goal. The example illustrates how the working-class husband and wife are often more isolated from each other than are their middle-class counterparts.[4] This is usually more painful for the working-class wife than for her husband. She is extremely dependent on her tie to her husband for a sense of stability. She needs his affection—at the very least, she needs his good will. Her view of men is that they are very independent; they go their own way and do not like to be nagged at or controlled by women. The working-class wife devotes herself to pleasing her husband, putting up with his wishes even when they entail considerable discomfort or displeasure for her. Very often she must put up with inconsiderateness from a man who is insensitive to her wishes and needs, and not inclined to modify his behavior even if he were more perceptive. She has little faith that she can be effective in modifying his behavior.

He tells her little or nothing about his work; the working-class housewife sometimes does not even know for what company her husband works. He often spends a good deal of his spare time on hobbies that exclude her—such things as hunting and fishing or endlessly working over his automobile engine. And the working-class housewife is often grateful that he is sufficiently absorbed in such activities not to gamble away his paycheck or chase other women. Any effort on her part to be closer to him, to be more intimately involved in what he is doing, is likely to be met with the reaction that she is nagging or trying to dominate him. In his view, marriage is an arrangement in which he provides an income and she runs the household and rears the children. It is also an arrangement in which she is obliged to gratify his sexual desires whenever he wishes.

For his part, the working-class man is

[2] Lee Rainwater, assisted by Karol Kane Weinstein, *And the Poor Get Children* (Chicago: Quadrangle Books, 1960).

[3] *Ibid.*, p. 20.

[4] For a detailed case study of one such family, *see* Robert D. Hess and Gerald Handel, *Family Worlds: A Psychosocial Approach to Family Life* (Chicago: University of Chicago Press, 1959), Chap. 4, "The Dynamics of Disconnectedness."

often troubled by his uneven performance as a bread-winner. The fluctuation of his income—which at its best is not much above subsistence—is a threat to his self-esteem, and it makes him uneasy about his performance as a man. As a man, he should be assertive, but he does not know how to channel assertiveness into economic rewards. He often feels defensive about his role as a provider.

Often, too, he feels confused by the demands for affection which his wife and children make on him. He does not know exactly what it is they want from him, and this makes him uneasy. He retreats to the masculine world of fishing, baseball, and tinkering with automobiles.

When difficulties between the marriage partners arise, they may bicker, fight, withdraw, or otherwise put up with the problem until it becomes intolerable to one or the other partner, at which point that partner leaves or files for divorce. The relative lack of insight, poor communication, and lack of deep trust in other people interfere with attempting to work the difficulty out in some collaborative way. One study has shown that among families broken by death or divorce and separation, the proportion of those broken by divorce and separation is far greater in the working class than in other social classes. In the upper middle class, for every family broken by divorce or separation, there were 9 broken by death. In the lower middle class, the ratio was 6 to 1. In the upper half of the working class, there were only 2 families broken by death for each family broken by divorce or separation. In the bottom half of the working class, 1.3 families were broken by divorce or separation for every family broken by death.[5]

OBSTACLES TO FAMILY PLANNING

It is in marriages of this kind that the greatest obstacles to family planning are found. People of the working class have the greatest problem with effective family planning, and their difficulties arise at several levels:

1. They less often use contraception.
2. They adopt contraceptive practices, if at all, at a later stage in their child-bearing histories than do middle-class people.
3. When they do use contraceptives, they are less likely to achieve their goals because they use them inconsistently.

Our evidence indicates that a very small proportion of working-class couples adopt contraception early in their marriage, nor do most couples discuss how many children they want to have. They simply have intercourse, believing that if "nature" or "God" or "fate" means for them to have children they will have them, and if not, then a pregnancy will not ensue. A small segment of working-class couples continues through the marriage to do nothing about contraception. They make no effort whatsoever to limit the size of their families, but simply accept or tolerate what nature visits upon them. Some of them want large families, but whether they do or not they account for their large number of children on the basis of this being what "God" or "nature" wants for them.

The vast majority of working-class couples do, however, at some time or other make some kind of effort to limit the size of their families. But their efforts are sporadic or careless, despite the fact that they have begun to wish for a limit to their family size. What prevents them from effectively implementing their wish?

The woman in the working class is usually more desirous of limiting her family, after she has had four or five children, than is her husband. By the time this wish is strong enough for her to want to take some effective action, the couple has usually tried the rhythm system and found it did not work for them. The question then is: what prevents them from adopting another method that would be effective? There are several reasons, varying in importance from case to case, which together hamper contraceptive effectiveness.

[5] August B. Hollingshead and Frederick C. Redlich, *Social Class and Mental Illness* (New York: John Wiley & Sons, 1958), pp. 91, 101, 110, 126.

1. They have doubts that planning can be effective. They doubt that they really can control their own future to such an extent as determining how many children they will have. There are two sides to this. On the one hand, they do not look ahead—do not anticipate that, three or four children from now, financial difficulties will be extremely pressing and the mother may become very weary from the burdens of constant child care. The other side is that they do not feel it is in their power to accomplish, by what they perceive as artificial means, a real interruption of what they consider "nature's laws."

2. A second reason for being unable to accomplish effective contraception is that husband and wife are often unable to agree on whose responsibility contraception is. The couple are often unable to get beyond the polarized position of each insisting that the other should take the responsibility. Since it is usually the wife who is most eager, after she has borne two or three children, to limit or prevent additional births, the husband often takes the position that his wife should do something about it. Besides, he is reluctant to interfere with his sexual spontaneity or accept a limitation of his pleasure by wearing a condom. His wife, on the other hand, often finds little pleasure in sexual intercourse. Her attitude is that it is a man's fun, so why should she pay the further penalty of unwanted pregnancies? Besides, it is his activity and sexual substance that makes her pregnant; therefore he should be the one who limits pregnancy, if he insists on his pleasure.

Another difficulty, very often, in achieving effective contraception is the working-class woman's attitude toward sexuality. There is a very widespread stereotype among middle-class people that lower-class people—women as well as men—are extravagantly libidinous, reveling in sexuality. Our study shows clearly that this is a very partial truth. For many lower-class women, sexuality remains an alien experience. Here is how one woman, married nineteen years and with four children, puts it:

> "He don't care how many children we have. He wouldn't care if there was one every time we went to bed; he don't do nothing to keep them from coming. The satisfaction is all on his part. I've never felt any pleasure from being with a man, but he sure must get something as often as he wants me. I've almost died every time I've been pregnant; every one has been a breech birth. What I go through never fazed him; the children themselves are the only satisfaction I ever got out of the deal." [6]

Many of the women with this kind of attitude toward sexuality keep so distant from it that they will not engage in the handling of their own genitals in order to use a female contraceptive method. And so the couple's efforts to limit family size often remain at a standstill. They remain unable to approach each other with sufficient candor, intimacy, or decisiveness to achieve a solution to their problem.

INDIVIDUAL MUST ASSUME RESPONSIBILITY

Not all remain at this impasse. Some couples, pressed by the increasing financial burden of several children and growing concern about the mother's health, try finally with desperation to utilize contraception effectively. Those who succeed in preventing additional unwelcome births are likely to be partners not as distant from each other as those we have been describing, who have some ground of affection and intimacy to build on, with the wife more accepting of her own sexuality.

Another type of working-class couple is effective in practicing contraception: the wife in this kind of partnership does not accept her own sexuality, nor is her husband especially considerate—rather, by

[6] Rainwater, *And the Poor Get Children, op. cit.*, p. 85.

one form of pressure or another, she succeeds in badgering him to use a condom, very much against his own wish. This is a solution to the family's problem of excess fertility, but within a framework of emotional distance and hostility of the spouses.

The problems that arise from the way of life described above are formidable. Their solution will not be easy, but we also cannot take the extreme relativist point of view and say, "This is another culture, another way of life, and these people are entitled to live according to their own lights." In our kind of society there is, ultimately, no alternative to the individual assumption of responsibility. Social work has an important role to play in fostering this objective, but it is not entirely social work's undertaking. The larger society also must address itself to the task. Economic growth facilitates the movement of these people out of the morass in which they live, and with growing prosperity more and more people manage to dig their way out of their meager and uncertain world to a more stable plane. It is clear that there will have to be a good deal of research and a great many experimental action programs to find out how they can be reached and helped to achieve a more satisfying and less disrupted life. The social worker who comes into contact with people from this stratum of society must understand what kind of lives they lead, what has shaped their lives, and what resources they have for altering them. Communication will be more difficult than with others, and the social worker will have to acquire some of the fortitude with which the clients at their best deal with their difficult lot.

BY HYMAN J. WEINER

Toward Techniques for Social Change

IT IS DIFFICULT, if not impossible, to read a social work publication or attend a conference where reference is not made to the need to "put the 'social' back into social work." The authors or speakers plead with the social worker to interest himself in social conditions affecting the client. Yet in spite of these many exhortations, relatively little concrete social action is evident. Why is this?

One must respond to the question on many levels. Herbert Bisno emphasizes the social work profession's quest for status and the consequent fear of "rocking the boat."[1] Lloyd Ohlin highlights the rapid rate of organizational change in the field as well as the conformity process built into social work practice.[2] The purpose of this paper is to identify still another dimension—the social worker's view of agency as a major obstacle in assuming social change functions—and to suggest an alternate view.

The basic assumption is that the social worker is being simultaneously bombarded with the need for his activity in the social change process and hampered by lack of opportunity to translate this conviction into concrete action. Subjective interest in altering a profession's direction is not enough; one must have the avenues and opportunities as well. Currently, a social worker may become active in his professional association or in his community as a citizen, but little possibility exists for him to integrate a social change role with his daily job. The contemporary call for social action is creating a new strain in our recent graduates, who leave school anxious to help individuals and also to "change the world"—only to find themselves doing so one client at a time. Cynicism flourishes with this disparity between aspiration and opportunity. This paper will attempt to show that by altering the "traditional" view of the agency, a number of paths should be revealed along which the social change role can become more of a reality.

To date a rather static approach to teaching of social agency characterizes both educational and field arenas. The implicit assumption is that the social agency is the "house that houses" the client-worker relationship. It serves to define the direction of the relationship as well as the social services given, but is more or less reduced to a background phenomenon. Emphasis on the need to "identify with agency" marks this point of view. Thus the tendency is to limit the social worker's understanding of the metamorphosis of agencies—how they change, and how social work is *more than* casework or group work method.

Another consideration is the fact that the interests of the social work profession and of any given agency may be identical, may not wholly coincide, or may actually conflict. Robert Vinter states the position well.

> The profession has an existence that is both independent of and more inclu-

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[1] Herbert Bisno, "How Social Will Social Work Be?" *Social Work*, Vol. 1, No. 2 (April 1956).

[2] Lloyd Ohlin, "Conformity in American Society Today," *Social Work*, Vol. 3, No. 2 (April 1958).

sive than agencies and services. Professionals are presumably dedicated to selfless service and the enhancement of their special competencies. They receive a more or less clear mandate from the public to use their skills in a given area of service and are ultimately accountable to the public for this mandate. Agencies are essentially instrumental means, rationally organized in the pursuit of specific goals. Although agencies and professionals function interdependently, they are different entities and have different interests.[3]

The inability to separate the interests of the profession from those of the agency leads to many complications in our field. Unfortunately, a number of schools of social work still tend to function as "vocational schools" for agencies rather than as free-wheeling, educational-professional institutions.

There are two important trends in agency development which make it all the more essential that we review our previous assumptions. First, agencies are increasingly assuming a multifunctional character. Second, they are increasing in size, degree of professionalization, and tendency toward bureaucracy. We will here attempt to focus theoretical material dealing with agency structure and social change on the following two questions:

1. How can we best appraise a social agency with a view toward social change possibilities? (What are the realistic targets within both the agency and the community it serves?)

2. What is the optimum role a social work department and social worker can play in the agency as a social change agent? (What considerations does each different target require? What are the leverage points?)

A public crisis in a large municipal hospital is presented as a case study in order to throw light on these questions. A crisis situation is used because it illuminates the anatomy of an agency as it struggles to restore its equilibrium.[4] Sykes believes that organization can be conceived as a series of crises held within limits—that routine may be simply an ideal around which actual behavior fluctuates.[5] We will examine here a situation in which a small incident in the life of a hospital touched off a crisis. In many ways it was an event in the normal life of the hospital coming at a time when public criticism was organized to exploit it. The etiology of the event, as well as the hospital's response to it, will be reviewed.

FOOD RIOT: A CASE STUDY

On a weekday afternoon in November, a leading newspaper carried the following headline and story:

FOOD RIOT AT CITY HOSPITAL

Fifteen patients in the new University Memorial Hospital rioted over the weekend because of bad food conditions. They said, "We are hungry and we just couldn't take it any longer." Near bedlam reigned for 10 minutes about 5:00 P.M. Sunday in the third-floor rehabilitation dining room, patients revealed. "They served us some kind of dark soup and eggs so old they were practically green. We just couldn't stand it." About fifteen dumped their trays. Food, dishes, and liquids flew all over the place. No one was hurt but an aide's uniform got splashed. Hospital Commissioner Williams, informed of the incident and complaints, said he would have "an immediate and complete investigation and report" of conditions there. On the surface the sleek $20,000,000 institution for aged and ill who

[3] Robert Vinter, "Group Work: Perspectives and Prospects," in *Social Work with Groups 1959* (New York: National Association of Social Workers, 1959), pp. 128–129.

[4] In this discussion a hospital is viewed as one kind of agency. Others include prisons, treatment homes, and family counseling or group service agencies.

[5] Gresham Sykes, *The Society of Captives* (Princeton, N. J.: Princeton University Press, 1959), p. 109.

need help is a model of cleanliness and comfort. Its floors and walls fairly gleam. The most modern-style couches grace the lounges.

It was the younger ones who rebelled. "The older patients don't complain," they said. "They know they will never have any other place to go and they just accept it. But we are here to be rehabilitated, but everyone passes the buck. The doctors say, 'What can we do about it?' The hospital people say, 'Oh, that's good food, what is the matter with you?' " One claimed that the care was nearly as bad as the food, explaining, "My feet haven't been washed since July, because I can't do it myself . . . the P.N.'s [practical nurses] sit around and crochet. . . ."

The newspaper continued this story line as a special feature for the next five days. Special investigators and newspapermen descended upon the normally quiet hospital scene.

For a month prior to this incident, patients had been expressing discontent with the food. The young adults were the most vociferous objectors. At least twenty-four hours before the tray-throwing, the group worker and chief nurse were jokingly told by a few patients, "Something sure is gonna take place around here." At supper next day, at a prearranged signal, three patients threw their food-laden trays off the table (the news account exaggerates the number). At that precise moment another patient wheeled herself to the public telephone and called the newspaper.

The following day a group of doctors and medical administrators from the Department of Hospitals visited University Hospital. They quizzed the superintendent, her staff, and selected groups of patients. The dietary division felt the brunt of the main critical blows. They tried to shift the blame to the nursing division, whose responsibility it is to serve the food. A series of staff meetings were called on the rehabilitation service and the following recommendations were approved:

1. Physicians and therapists in the rehabilitation department will eat lunch on the wards with the patients on a rotating basis.

2. A ward administrative committee will be organized, under the leadership of the director of clinical service, to be concerned with ward living problems.

3. Consideration will be given the special needs of the young adult population on the ward.

4. There will be the establishment of a new administrative nursing position, to be responsible directly to the director of rehabilitation as well as to the director of nursing.

Simultaneously, representatives of University Hospital, the Department of Hospitals, and the medical school associated with the hospital agreed to: (1) carefully review the situation in the dietary division and consider ways of improving it (within three months the chief dietitian resigned and was replaced by a young and dynamic person); (2) meet regularly with the (then infant) patients' council and open lines of communication between patients and administration.

Two weeks following the food incident the director of rehabilitation invited reporters from the interested newspaper to visit the hospital. They were given a tour, met with patients and staff, and next day printed a story describing how the hospital was sincerely moving in a constructive direction to improve the situation.

REDISTRIBUTION OF POWER

Certain stresses and strains in the hospital set the stage for this crisis, and certain conflicts touched it off. A temporary breakdown of accommodation between patients and staff occurred. Description and location of the underlying as well as of the immediate stresses and strains are in order. A basic assumption of this paper is that the crisis marked a momentary redistribution of power both within and outside the

hospital. It was especially during the week following the incident that the hospital structure and the interest groups directly involved [6] or simply interested in the hospital's functioning became visible as they maneuvered with each other.

University Hospital can be conceived as a point in social space where a number of interest groups converge (medical school, Department of Hospitals, and so forth). Each of these groups, in the process of pursuing its own interests, moves in and out of coalitions with others. Interest groups within the hospital interlock with groups in the larger medical beaucracy or in the community at large. Power is distributed unequally among these groups. *It is in redistributing this power that significant change takes place.* In order to redistribute this power, understanding of the relations of the interest groups to each other, both within and outside the hospital, is a necessary prerequisite.

The use of the concept *power* requires clarification. This idea is generally associated with authority and force, and carries negative connotations. It is widely understood to be "that which makes people do what they may not choose to do voluntarily." [7] This partial view obscures a deeper comprehension of the relation of power to the process of social change. Under the above formulation we think of it in static terms—"those who have it and those who don't." This is a definition of power at the extreme end of a continuum that ranges from influence to force.

Power is differentially distributed in any social system, *i.e.*, organization or institution. Each social system can be conceived to be in a state of tension, a sort of "tug-of-war" between the different holders of power. It is helpful to view power as energy, which flows in many directions and can be created as well as mobilized. As with energy, one cannot subject power itself to examination, but one can study its effects on the social system and even locate its source and basis of generation.

The view presented here is that power is generated by interest groups through the ability of the group to control or influence the necessary resources that enable the social system to survive.[8] Each interest group may have its own "version of order" or "policy" that it wishes to impose upon the total system. Each may control some aspect of the resources, but the groups that wield major control are those that seriously influence policy. Versions of policy can be modified, even greatly altered, when other interest groups enter into coalition and begin to mobilize their latent power. The crisis described above set in motion some of these groups, which mobilized enough power to introduce certain changes in the organization. Let us first examine the network of interest groups in some way implicated in the functioning of University Hospital (see diagram on next page).

FEATURES THAT PRODUCE STRAINS

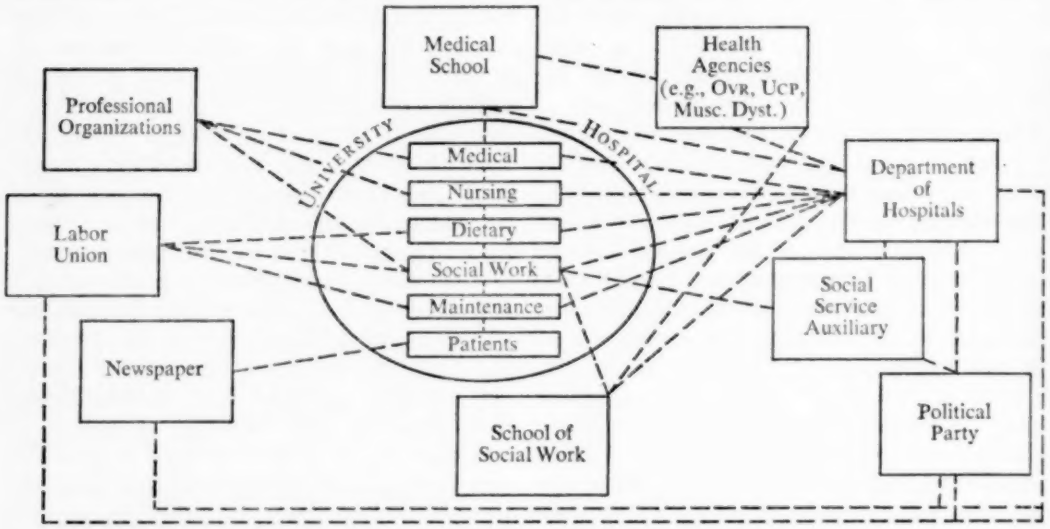
The diagram reveals at least three significant structural features serving to produce basic strains in the system: (1) nonconcentration of power, (2) departmental autonomy, and (3) informal power structure.

[6] Lloyd Ohlin states that "the term 'interest' is used to denote a line of current or future activity in which a person or group has invested action, resources and expectations." *See* "Interest Group Conflict and Correctional Objectives" in *Theoretical Studies of the Prison* (New York: Social Science Research Council, 1960), p. 111. The writer expresses his appreciation to Lloyd Ohlin for the fundamental ideas pertaining to interest group theory used in this paper.

[7] Elaine and John Cummings, "The Locus of Power in a Large Mental Hospital," *Psychiatry*, Vol. 19, No. 4 (November 1956), p. 362.

[8] For an interesting discussion in this vein *see* Robert Lynd, "Power in American Society as Resource and Problem," in Arthur Kornhauser, ed., *Problems of Power in American Democracy* (Detroit, Mich.: Wayne State University Press, 1956), pp. 36–38. Emphasis on the redistribution of power does not imply that the total amount of power in the social system remains fixed. The range of interest groups involved affects the amount of power generated, as well as its redistribution.

UNIVERSITY HOSPITAL NETWORK OF INTEREST GROUPS



Nonconcentration of power. As stated above, power is unequally distributed through this hospital social system, and there exists no monopoly in any single group. The Department of Hospitals actually derives its power from responding to a multitude of interest groups, some of which are in sharp disagreement with each other. This is a common feature in the *public* large-scale organization in which policy is more visible to public scrutiny and particularly sensitive to open criticism. The nonconcentration of power encourages policy formation at a *least-common-denominator level,* which may not please but at least will not antagonize too many interest groups in this loose coalition. Basic patient need coverage—medical care, food, living facilities—becomes the level of service aimed for. A custodial rather than a therapeutic philosophy emerges and flourishes in this situation. (A therapeutic philosophy of care raises controversial questions of budget, nature of the case load, and eventually the need to institute far-reaching changes. This would require a clear mandate to the hospital administration, fully supported by enough power in the Department of Hospitals willing to risk alienation of certain interest groups.) Organizational maintenance at the least-common-denominator level of care becomes the hospital goal, and power is diffused through the total social system.

Departmental autonomy. The diagram shows that each department in the hospital—medical, nursing, and so on—has its counterpart in the Department of Hospitals. University Hospital tends to function as a combination of autonomous divisions co-ordinated by a superintendent. Thus a situation of dual authority exists. The administrative authority of the hospital superintendent tends to be undercut in this situation. The boundary of this bureaucracy is actually not University Hospital but the Department of Hospitals. Professional and departmental allegiances flourish, rather than a common focus on problems of patients in the hospital. In part, this explains why the chief dietitian became the central object of attack in the crisis rather than the hospital superintendent. Accountability travels in a horizontal rather than a vertical direction.

Informal power structure. As a result of the above two features (nonconcentration of power and departmental autonomy), the need arises for informal accommodations in a vertical direction between departments. A continual process of *trading in power* occurs, and an informal power structure evolves. This informal system may or may not be in harmony with the ascribed power dictated through the formal bureaucratic structure. At University Hospital this situation can be illustrated as follows from the most to the least power. The numbers signify ranking of ascribed and actual power, and do not have any numerical significance.

Groups [9]	Ascribed Power	Actual Power
Medical	6	4
Nursing	5	6
Social work	4	3
Dietary	3	5
Maintenance	2	3
Patients	1	1

As can be seen, medical authority has been abrogated. The medical school, responsible for medical care at University Hospital, is primarily interested in teaching and research. Its view of a physician's responsibilities does not include administrative control over medical and social care, and by default yields to the nursing division for supervision of these functions. More power accrues to the dietary division than is called for in the formal structure, as a result of the sensitivity of the social system to public criticism of poor food. The need for supplies and repairs in an economically impoverished institution permits the steward, carpenter, and store clerk to wield equal power with social workers. Staff expectations of each other's behavior are shaped under the impact of a social structure which permits the accumulation of power to be based on access to needed resources rather than professional skill.

[9] The Rehabilitation Service at University Hospital functions administratively as a department and encompasses many medical and therapeutic professions. Actually it is the major power in the hospital, but this power is delegated by the medical school rather than as a department in the hospital hierarchy.

PRECIPITATING CIRCUMSTANCES

The above three features result in basic strains on the organization which set the stage for the crisis. In addition to the poor food situation, we shall consider two immediate circumstances that resulted in the food incident. They are (1) succession (replacement of one medical superintendent by another six months prior to crisis), and (2) administrative "buck-passing."

Succession. Six months earlier a well-liked, somewhat authoritarian but patient-centered superintendent had resigned and was replaced by a patient-centered but passive administrator. In the absence of aggressive and affirmative administration at University Hospital, the three basic strains began to assert themselves. These strains exist normally only as tendencies, which may be affected and even neutralized by unusually competent administration, in which informal ties develop and staff of all departments voluntarily accepts administrative leadership. The transition from assertive to passive leadership created a situation where petty nursing tyrants on some wards reasserted their power, and the physicians in turn became preoccupied with teaching and research. Within the bounds of bureaucratic role designations, paternalism became noticeable in each department.

Administrative buck-passing. One of the patients in the newspaper story complained, "Everyone passes the buck." The patients do not know *who has the power.* Only certain lines of authority are evident to them—*i.e.,* the physician okays discharge and weekend passes, but they are unclear about who takes responsibility for ward living problems. The patients run directly into a departmental autonomy situation in which the nurse passes responsi-

bility to the doctor, the doctor to the administrator, and around it goes. Occasionally, group meetings are organized for patients to voice their dissatisfaction and offer recommendations, but administrative follow-through is lacking. In addition to the departmental autonomy described above, another dual authority problem remains.[10] Power is ascribed to each department in the hospital hierarchy, but any physician who so chooses may exercise authority outside this hierarchical scheme. At University Hospital this is done only in regard to individual patients and not in relation to the ward as a whole. The philosophy of treatment does not attach much significance to the ward as a living unit. It is viewed as a backdrop phenomenon in which the patient resides between therapy periods. As a result, the physician avoids taking any responsibility for ward living, and power in turn reverts to the nurse. In this buck-passing routine even the nurse is unable to follow through effectively, for she is involved in a complex network of accountability systems. The dietitian and the maintenance man, in given situations, may be in a better position to guarantee follow-up in their respective areas than the nurse, for they control needed resources.

These basic strains and immediate circumstances in the University Hospital social system generated the "incident," but the readiness of a public audience is necessary if the incident is to become a crisis. The Department of Hospitals had been under periodic attack by the city newspaper that decided to feature the food situation. This newspaper had been critical of the city administration during the previous year. It supported the mayor, but most reluctantly. When a middle-aged patient, formerly a professional (thus considered reliable), called them, they jumped at the opportunity to attack the city administration. The Department of Hospitals publicly replied that it would investigate and immediately examined the University Hospital administration as well as its dietary department and counterpart in the Department of Hospitals. The health agencies that were in part subsidizing programs of the medical school began to urge that the situation at University Hospital be immediately improved. The medical school, in turn, began to hammer at the Department of Hospitals. Once public pressure began to mount, the labor union which had recently organized six hundred of the eighteen hundred employees revealed that employees as well as patients were the scapegoats. There was an absence of any organized coalition at the outset, but within three days two loose coalitions could be identified. The Department of Hospitals and the medical school constituted one, while the newspaper, two health agencies in the city, the labor union, and the school of social work comprised the other. These two coalitions reflected different policies. The first favored a custodial approach, the second a shift to more active treatment.

IMPLICATIONS FOR SOCIAL WORK

This case study is not submitted as a social work, or social change, success story. The purpose is rather to suggest a framework within which to view the social institution defined broadly as "agency." An agency is seen as a network of interlocking interest groups. The interests of the agency and of the social work profession are not necessarily identical. Policy formation is regarded as the resultant of power distributed unequally throughout each agency's network of interest groups.

Lydia Rapoport in a recent issue of *Social Service Review* makes the following statement: "Social workers, therefore, have to maintain a dual identification and loyalty, both to the agency and to the profes-

[10] *See* Harvey Smith, "Two Lines of Authority: The Hospital's Dilemma" in E. Gartly Jaco, ed., *Patients, Physicians and Illness* (Glencoe, Ill.: The Free Press, 1958).

sional body, with *the primary tie being to the agency* [emphasis supplied]."[11] This assertion that the social worker's primary identification belongs to the agency serves as a serious obstacle, limiting social change possibilities within both the agency and the larger community it serves. It does so by viewing agency policy as having monolithic unity. It does not take into consideration different versions of policy held by various interest groups. This holds true in social work agencies as well as in settings where social work is one among a number of disciplines. We do not suggest that a social work department is capable independently of seriously changing large bureaucratic settings or communities, but rather that significant inroads can be made through the mobilization of interest groups and subsequent generation of power.

In this case study, the social work department did not seek to set in motion the interest groups related to it or sympathetic to its position during the crisis period. There was a reservoir of at least five such groups, including (1) a school of social work, (2) the professional social work organization, (3) the social service auxiliary, (4) the labor union representing social workers, and (5) the social service department in the Department of Hospitals. A coalition among some of these groups might have enabled the social work department to increase its power as a social change force. Throughout the crisis period the social work department refused to "placate" the patients. The social workers were unable to accomplish as much as they would have liked—that is, they were able to counteract the view that individual "trouble-makers" among the patients constituted the core problem and to help establish medical authority in ward living, but little more. A more ambitious social change target could have been considered within a coalition approach: that of altering the custodial approach to treatment in favor of a more therapeutic one. The psychologists, therapists, and certain sections of the medical staff may well have been ready to enter such a coalition.

[11] Lydia Rapoport, "In Defense of Social Work," *Social Service Review*, Vol. 34, No. 1 (March 1960), p. 71.

LEVERAGE POINTS

It is not enough to identify the existence of power relations if we wish to alter them. One must provide handles or leverage points which can help us to effect their rearrangement. C. Wright Mills' *The Power Elite*[12] dramatically describes our national network of power and interest groups but leaves one with the unanswered question, "What can we do about it?" It is interesting to note that *The Dynamics of Planned Change* is being snapped up in our profession, for, though less dramatic, it does provide a way of assessing a situation with suggestions for active intervention.[13]

In reconceptualizing our view of agency it is equally important to reconsider certain internal features characteristic of social work functioning. These include (1) extension of the diagnostic process, (2) alterations in the clinical role model, and (3) new division of labor within a social work department.

Diagnostic process. The diagnostic process should be extended to include problems transcending individual clients, either within the agency or in the community. This implies that the term "client" or "unit of service" may not be identical with an individual. A social change target would become the object of systematic social work intervention. The crisis situation was submitted as a diagnostic statement involving the total hospital as the actual client or unit of service. The call for extension of the diagnostic process refers to the application of a systematic problem-solving procedure. Unfortunately, there is a decided absence of social science theory in the area

[12] New York: Oxford University Press, 1956.

[13] Ronald Lippitt, Jeanne Watson, and Bruce Westley, *The Dynamics of Planned Change* (New York: Harcourt, Brace & Company, 1958).

of social change. As was true in social work, earlier social scientists defined their core role in connection with the social problems of the day. Currently most social science theory avoids controversial questions, and when it does address itself to the change process it is with an interest in maintaining equilibrium. It is particularly in this area that the combined efforts of social work and social science can probably make their most significant contribution. In any given period of professional endeavor, a social work department could enumerate a number of social change targets, each calling for a different plan of intervention. The diagnostic procedure would seek to identify specific "treatment" approaches.

Clinical role model. Currently social work departments shape their clinical model around method competence. Thus medical social work is defined as casework in a medical setting, or the group worker in a residential treatment setting makes his claim to social work identity via the application of group skills. But social work is more than competence in any single method. Sound assessment of a social problem cannot be made effectively if the social worker is wedded to a given method diagnostically. He then tends to define each problem in terms of his capacity to deal with it. It is interesting to note how often caseworkers define agency and community problems in terms of the personality of the administrator or community leader.[14] The group worker characteristically reduces these problems to group interaction or the need for democratic processes. The call is not for treatment competence on individual, group, and community levels, but for the ability to *appraise* a given problem within this threefold perspective—though this would suggest, certainly, that more social workers should become adept in group and community processes in a "treatment" role.

In emphasizing the need for social action the cry "We are too oriented to technique and methodology!" is often heard, implying that social change content thus is abandoned. This is a misleading assertion, for one cannot separate technique from content. It is not that we have been too technique-oriented, but rather that the content has been the individual client, with emphasis on intrapsychic phenomena. Actually we are not technical enough in the social change arena, and unless we develop methodology in this content area there will be little action. The new clinical model should include the social change component. This development cannot come about as long as social work defines its core contributions as casework, group work, or community organization method.

Division of labor. In most situations the supervisor or administrator is able to play a more active role in social change matters than the staff social worker. The practitioner's contribution is generally reduced to one of communicating the problem to his supervisor, who in turn sends it up the hierarchy. A new division of labor is in order if the social change component is to be added to the social work role model. Current developments in the area of supervision have created a fertile field for this shift of functions. A more independent worker is required to fulfill social action expectations. *A total departmental view of social change is required.* Staff meetings may be used to appraise social problems, followed by a division of labor necessary for particular problems. The nature of the social change target may require assignments not consistent with a division of labor based upon method, or supervisory responsibility.

CONCLUSION

Separation of the interests of the agency from those of the profession is suggested

[14] Even when a social worker happens to be in the role of administrator, he is not a free agent. He is functioning in the role of mediator among interest groups, and as representative of the board or of the dominant groups, not *necessarily* his group of origin: the social work profession.

in this paper as one conceptual scheme that may offer new social change opportunities to social workers. A case study was used in order to elevate social change considerations to the same diagnostic and intervention significance as is necessary to help individual clients. The time for social change theory to address itself to practice principles is now. It is doubtful whether exhortations produce anything more than guilt, and subsequent anxiety. If social change technique is to be an integral part of social work skill, it is primarily the social workers who will have to do it. Our field and the social problems it deals with are currently attracting the interest of social scientists, but we cannot look to social science research teams to provide us with immediate answers. These researchers are caught in the same interest group arrangement as the social workers.[15] It is a rare social agency that encourages a research team to engage in studying controversial questions. Only when our profession is represented by a sound and powerful profession organization, and supported by policies of schools of social work less responsive to agency dictates, will social workers be able to implement a social change role. The less conservative political climate, recent demands for complete racial integration, and interest in extending health and welfare services have set the stage for new social change possibilities. It is up to the social work profession to take advantage of this positive objective situation and translate words into action. This paper has attempted to identify some of the roadblocks interfering with such a translation.

[15] Arthur Kornhauser, "Power Relationships and the Role of the Social Scientist," in Kornhauser, ed., *Problems of Power in American Democracy*, *op. cit.* This is a particularly good discussion of the problem. The author inquires (p. 191) "What parts of society want what types of knowledge, to be used by whom, toward what ends? The point of the question is sometimes put to us in the sharper and more cynical form: 'Whose social scientist are you?'"

BY MARGARET M. HEYMAN

A Study of Effective Utilization of Social Workers in a Hospital Setting

THE SHORTAGE OF trained graduate caseworkers to man social work openings has been an acute problem for a long time and remains a matter of constant concern. Serious as it is, the situation is compounded by increasing demands for trained workers and their continuing departure from the field. The result is an almost fixed number of available workers. Many references have been made in the professional literature to the necessity of using trained workers to best advantage, and—particularly in the hospital field—to the urgent need for changes in staffing patterns in hospital social service departments.

This paper describes the method employed in applying and evaluating one approach to alleviation of the social work manpower problem in a hospital setting, by an allocation of work on the basis of level of skill. This investigation, begun in January 1959, took place at the Albert Einstein Medical Center in Philadelphia. It was supported by a Public Health Service research grant from the National Institute of Mental Health. Since it has not been completed, no findings will be reported at this time.

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With the traditional method of assigning professional staff in a hospital that of giving each worker total social service responsibility in a particular clinic or service, a professionally trained caseworker performs a variety of services which may or may not require his full skills. Such utilization of staff is not economical. Underutilization of the trained worker's full skills not only lessens effectiveness, but the best interests of patients as a whole may not be served. The central idea under study is to use professionally trained caseworkers at the level of their greatest skill, so that either more or better service—and hopefully both—will be available to patients and their families, and time will be saved by professional staff so they can increase the spread of their services. If this approach is successful, it is hoped that it will have applicability to other settings, particularly other hospital social service departments, where it may serve as a partial answer to the shortage of professional manpower.

The research design encompassed the demonstration and testing of a central plan of assigning cases on the basis of criteria for four levels of staff: senior caseworker, caseworker, case aide, and secretary. By identifying various elements in the case during the intake process and the duration of the case, it was planned to determine the lowest staff level at which the case could be responsibly assigned and carried—with fullest consideration for casework implications, such as continuity of relationship, and the human values for both patient and the staff. Entire responsibility for a case could

be given to any level except secretary. After assignment of the case, partial responsibility could be delegated by both levels of caseworkers to case aides or secretaries on the basis of defined criteria, or entire responsibility for it could be transferred when additional elements were revealed that required a different level of case handling. This administrative change will be described, and three approaches used to evaluate its effects: on the productivity of the department, the quality of its service, and the perception of the department's activity by staff.

CENTRAL PLAN OF ASSIGNING CASES

The staff had developed criteria for assignment of cases to case aides and to two levels of caseworkers, over a period of three years of experience with case aides prior to the beginning of the study. Some criteria for secretaries had to be developed and certain administrative steps taken within the hospital before the new plan of case assignment could be used appropriately within the department. Since caseworkers and case aides alike had been carrying traditional responsibility for Services, it was necessary to rearrange the Service assignments, delegating to professional staff the responsibility for relationships with physicians and hospital personnel on the various Services. This was essential, since with the new system different workers at all levels except secretary might carry cases on the same Service. General interpretation of the new method to physicians and team members was an essential step in its implementation, as well as individual interpretation on a case-by-case basis.

The criteria developed for the new case assignment system, whose utility became the basis for the study to be outlined below, are as follows:

Requiring Advanced Casework Skills

1. Independent on-the-spot casework treatment required because of the nature of the emotional disturbance in the situation.

2. Independent on-the-spot casework judgment essential to secure the recommended vital medical treatment.

3. Serious administrative implications related to public relations; administrative expedience; or educational purposes.

Requiring Casework Skills

4. Presenting diagnostic considerations:

a. Obvious ambivalence to, resistance to, or rejection of medical recommendations.

b. Obvious hostility toward or anxiety about the diagnosis, treatment, and hospitalization. An unusual degree of defensiveness in the behavior of the patient or relatives. Inappropriate reaction to the illness.

c. Disturbance of the individual and/or family relationships.

d. Personality attributes of patient or relative (*e.g.*, insecurity, dependency, helplessness, apprehension).

5. Anticipated co-operative activity:

a. Extensive collaboration with the team.

b. Difficult interprofessional collaboration.

c. Relationship with a professional social agency.

d. Reporting to a professional agency (verbal or written).

e. Difficult collaboration with a nonprofessional agency or with other individual members or groups of the community.

Not Requiring Casework Skills (Case Aide)

6. Discharge planning.

7. Information for department of public assistance.

8. Information indicated via school attendance forms.

9. Help with securing appliance (glasses, braces, shoes, hearing aids, wheelchairs, and so on).

10. Help with financial assistance.

11. Willow Crest application.[1]
12. Gathering pertinent information from medical charts.
13. Courtesy and explanation services.
14. Finding nursing home vacancies.
15. Preparing lists of appropriate facilities (nursing, boarding, convalescent homes, institutions) for individual situations.
16. Information-gathering from relatives or patients.
17. Information-gathering from community resources or vendors.

Requiring Neither Casework Skills Nor Medical-Social Data (Secretary)

18. Making appointments.
19. Information-gathering from community resources, vendors.
20. Courtesy and explanation services within SSD office.

It was decided that for purposes of differentiated assignment is was neither important nor possible for one person to handle all the intake; rather the principle was developed that the same person should review all the assignments to insure uniformity in the application of the criteria at point of assignment.

APPLICATION OF THE CRITERIA

The purpose of this intake process was to perform only the minimum activity necessary to determine the level of staff appropriate to carry the entire responsibility for the case. Keeping the case activity to a minimum number of steps was important to reduce the possible negative effects in the transfer to another department representative and the time span between referral and assignment. The time between referral and assignment generally did not exceed two days.

The amount of activity in the intake process required for the appropriate application of the criteria varied according to the individual situation. Whether long or short, the intake process involved careful evaluation in order to assure assignment to the appropriate level with a minimum number of steps. Effort was made for the caseworker's skill to be used only where his level of skill was required. It was nevertheless important that standards of quality be maintained at whatever level the assignment was made.

For comprehensive use of the criteria, each staff member (except for secretary) needed to be familiar with the criteria applying to all levels. Then, with alertness to the needs of the case, indications for partial assignments or for the transfer of the case to another level could be easily recognized. For example, a case aide might co-operate with a worker in a partial assignment for "courtesy and explanation service" (No. 13), helping the patient to fill out his social security application and visiting him to assure him of the caseworker's interest when it was not possible for the caseworker to see him each day.

Cases could be transferred between levels when required by changes in the case situation. For example, the responsibility for a case might move from senior caseworker to caseworker when the elements in the case changed from "independent on-the-spot casework judgment essential to secure the recommended vital medical treatment" (No. 2) to "obvious ambivalence to medical recommendations" (No. 4a) and "an unusual degree of defensiveness in the behavior of the patient" (No. 4b). Vertical transfers could also take place when it became apparent in the course of the case that it had originally been assigned to the incorrect level, as in the instance of a transfer from a case aide to a caseworker when "disturbance of the individual and/or family relationships" (No. 4c), unrecognized in intake, later emerged.

EFFECTIVENESS OF PLAN

The effectiveness of the case assignment plan was to be evaluated in terms of productivity, in two senses: quantity and quality of service. Increase in quantity (in case

[1] This refers to a local facility for convalescent care.

load, time spent with patients, and so on) would not necessarily be desirable if poorer service were the result. While increase in quality achieved by severely reducing quantity may be desirable under certain circumstances, despite higher per capita cost and other consequences, it was not an objective of the case-assignment plan. Changes in both quantity and quality were the objectives.

1. *Productivity: quantity of service*

With respect to quantity, the study was concerned not only with changes in case load and total interviewing time, but with the time investment in supporting activities, such as supervision, recording, and attendance at clinical conferences and rounds. In other words, an increasing productivity, in terms even of an increase in number of patients seen by a worker, would not necessarily be deemed a desirable outcome if it meant, for example, that there was *no* supervision, *no* recording, *no* attendance at clinical conferences and rounds, or the like. Several criteria were utilized to assess productivity, and these were used differentially with different levels of staff.

To measure how much time was being spent in which activities by which levels, time studies were conducted at four different intervals, each for five consecutive days. It was anticipated that they might point up some change in the use of time as the new assignment method became more refined in its application through continuous use. An attempt to account for all time in the job was not made. The time schedules were designed to record only what is termed "productive time"—*i.e.*, time spent in direct and indirect service to patients.

If the case assignment method were effective, it was hypothesized that a number of changes in the pattern of time investment would ensue.

a. The senior supervisory workers would devote less time to actual casework activity, but the cases carried would receive higher per capita time; no time would be spent in activities that could be performed by case aides; recording time would decrease; and more time would go into supervision, consultation, and attendance at clinical conferences and rounds.

b. At the caseworker level, the expectation was for a minimum of time on activities that could be performed by case aides, about the same amount of time on recording, and more time in direct interviewing of patients and relatives and conferring with the doctor (particularly more time per case in these activities), and more time in taking supervision, giving consultations, and attending clinical conferences and rounds.

c. The case aide, it was expected, would spend less time on recording, no time attending clinical conferences and rounds, and more time implementing casework activity.

d. It was hoped that the secretary would spend increased time on the three items related to her circumscribed activity, leaving more time for case aides to work on their assignments.

All these possibilities were to be scrutinized through the periodic time studies as the study progressed. If the logic applied was correct, the various expectancies mentioned might serve as a check on the progress made in application of the new assignment method. From the time studies, the pattern of time expended in key activities in various periods might readily be seen.

2. *Productivity: quality of service*

The possibilities resulting from the change in the case assignment method in relation to more or less quantity and quality may be seen in the following:

	Quantity	*Quality*
1.	+	+
2.	+	same
3.	same	+
4.	+	−
5.	−	+
6.	same	same
7.	−	−

Possibilities 1, 2, and 3 would justify a change. Possibilities 4 and 5 would be questionable and would depend on the relative degree of change in quantity and quality. Possibilities 6 and 7 indicate no justification for a change. Naturally the optimum result would be Possibility 1, representing an increase in both quantitative and qualitative aspects of productivity.

Some method of measuring the effect on the quality of service of the new case assignment plan needed to be devised. A control group was administratively unfeasible. The comparisons were finally made on a before-and-after basis at one division of the hospital.[2]

Quality in this study is not defined in absolute terms. There is no generally accepted absolute standard of good casework in a hospital setting. The Case Reader Schedule devised for use in this study was not intended to gauge how good or poor the casework was at any one time. It serves, rather, as a gauge of *change* in the quality of casework over periods of time. *It is designed to indicate the relative extent to which casework improves or deteriorates over time in the same setting.*

For these reasons, the Case Reader Schedule did not include every possible item that might be relevant in evaluating casework service. A list of items thought to characterize good hospital casework was drawn up. It was revised considerably over a series of seven pretests, in each of which two readers reviewed a random sample of cases. The items retained after pretesting were those that met the following tests: (1) information for judging the item would generally be included in the recording; (2) instances of both good and poor performance could be anticipated; (3) it would be relevant to this setting; (4) its terms would be precise and tend to be uniformly understood by experienced case readers. All the items were grouped under two headings—"Diagnosis and Plan" and "Treatment"—in order to provide a clear framework for the judges. The final instrument is reproduced in Fig. 1.

Three samples each comprising 100 case records were read and the Case Reader Schedule completed. The samples were drawn from cases closed in three different time periods. The first was a month immediately prior to the introduction of the first case aide to the department in October 1955, and therefore represented the department's experienced use of the traditional system of the assignment of individual workers to individual Services. The second period chosen was October 1959, when the staff had had six months' experience with the new system and any new staff would have been considered oriented to the setting. The third period, May 1960—at which time the new system would have been in effect about twelve months—represented some solid experience with the new system.

Each of the items on the Case Reader Schedule was judged on each case in relation to a scale of "Good," "Fair," and "Poor." A value of 3—2—1 was applied, in this order. An item could also be checked "Insufficient Information" or "Not Relevant."

In the final tests, each case was read by two of three readers.[3] In the absence of definitive tests of interjudge reliability, precluded by the small size of the pretest samples, it was decided to exclude cases that fell below a prescribed level of agreement. Agreement on an item consisted of ratings by the two readers not more than one step apart. If either or both case readers

[2] The Albert Einstein Medical Center is composed of two divisions, northern and southern, separated by a distance of ten miles. Each is a complete general hospital with its complement of social workers. The social workers of both divisions are considered to be in one department under one director.

[3] These case readers had no connection with the institution where the study was conducted, and were used as judges for the cases. They were chosen because of their generally acknowledged judgment and experience in medical social work.

checked "Insufficient Information" or "Not Relevant," this constituted nonagreement. The number of items on which agreement was required for inclusion of the case depended on the duration of activity on the case. Brief-service cases, those closed within nine days, required agreement between case readers on at least two of the items in the "Diagnosis and Plan" section. Short-term cases, open from 10 to 50 days, required agreement on at least 4 of the 13 items on the schedule. Long-term cases, open 51 days or more, required six agreements, with a minimum of one in the "Treatment" section. On the basis of these criteria, 167 cases were left in and 133 were excluded from the sample used to gauge changes of quality over the three time periods, as shown in Fig. 2.

3. *Measuring staff reactions*

In addition to the two major approaches to testing the effect of the new system of case assignment—*i.e.*, the effect on the quantity and quality of service—a third approach was utilized to help evaluate the reactions of staff to their professional activities in the department during the period in which the new system was being introduced. It was hypothesized that the staff's reactions to the department's total service and to their own performance would reflect operationally their reactions to the new assignment system itself.

CASE READER SCHEDULE

Case Number:

A. *Quality of Social Service Rendered (to be completed by Case Reader)*

	Good	*Fair*	*Poor*	*Insuf. Info.*	*Not Relevant*
1. Diagnosis and Plan					
a. Definition of the psycho-social situation in relation to the problem described in referral.	☐	☐	☐	☐	☐
b. Exploration beyond initial request for service, where there is sufficient indication for it.	☐	☐	☐	☐	☐
c. Worker's assessment of patient's personality and inter-family relationships.	☐	☐	☐	☐	☐
d. Plan in view of medical requirements.	☐	☐	☐	☐	☐
e. Plan in view of psycho-social requirements.	☐	☐	☐	☐	☐
f. Help to patient to participate in planning for needs of case.	☐	☐	☐	☐	☐
2. Treatment					
a. Intepretation of the psycho-social situation to doctor.	☐	☐	☐	☐	☐
b. Interpretation of the psycho-social situation to other team members.	☐	☐	☐	☐	☐
c. Use of community resources which are needed.	☐	☐	☐	☐	☐
d. i. Help to patient to act on suggestions regarding community resources.	☐	☐	☐	☐	☐
ii. Help to family to act on suggestions regarding community resources.	☐	☐	☐	☐	☐
e. Help to patient to modify his reaction to his illness.	☐	☐	☐	☐	☐
f. Help to family to modify their reaction to patient's illness.	☐	☐	☐	☐	☐

B. *General Evaluation of Case (to be completed by Case Reader)*

In view of your experience in medical social work, how would you rate the general handling of that period of activity being judged in this case? Check one:

Good ☐ Fair ☐ Poor ☐

Name of Case Reader:

FIG. 1

INCLUDED AND EXCLUDED CASES BY TYPE OF CASE
1955, 1959, 1960

Type of Case	No. Included Cases				No. Excluded Cases				All Cases			
	Total	1955	1959	1960	Total	1955	1959	1960	Total	1955	1959	1960
Total	167	60	45	62	133	40	55	38	300	100	100	100
Brief	21	9	10	2	12	4	7	1	33	13	17	3
Short	64	23	14	27	68	23	23	22	132	46	37	49
Long	82	28	21	33	53	13	25	15	135	41	46	48

FIG. 2

Any introduction of administrative change is likely to produce repercussions and side effects within the staff who are asked to carry it out. A measure of this effect, its nature and intensity, is important in evaluating the administrative change itself, not only *post factum* but particularly as the study proceeds. Attention to staff response during the study may spell the difference between success and failure of the administrative change. The basic question in the measure of staff acceptance is whether the administrative change works against or with the essential agreement of staff. There are four possible combinations of staff attitude and change in productivity (see Fig. 3).

Case 1. If the change resulted in improvement and the feeling of staff about it were positive, it might be said that part of the improvement in productivity was due to the staff's positive feeling or that they perceived the change as worth while and there was a "feedback" effect. At the very least, the change did not adversely affect staff or department.

Case 2. If the result were unfavorable staff reaction and no improvement, it could be inferred that staff saw little significance or value in the change, and that their view of it either was accurate or contributed to its lack of success.

Case 3. With a favorable staff response and no actual improvement, it might be said that the staff's more favorable attitude to the department had no effect on the system itself, and that the administrative change was probably not worth while, despite staff enthusiasm. Staff may have reacted positively to the change for reasons unrelated to the change itself—if, for example, it eased certain administrative pressures.

Case 4. Improved results with negative staff reaction would suggest that, even though staff was implementing the change, they did not like it for some reason, possibly because it made excessive demands on them.

An anonymous questionnaire was the principal instrument employed to gauge staff perceptions and reactions to (a) the activities of the department, (b) the effectiveness with which these activities were carried out, and (c) the use of casework skill made by the various Services in the hospital. The questionnaire was administered on three occasions, once during the

	Case 1	*Case 2*	*Case 3*	*Case 4*
Staff attitude	Favorable	Unfavorable	Favorable	Unfavorable
Productivity	Improved	Unimproved	Unimproved	Improved

FIG. 3

pretest period and twice during the data collection period.

4. *Methodological limitations*

A number of problems were encountered in the development of the study method, only some of which will be briefly mentioned here. There was an absence of true before-and-after situation on two counts. In the first place, it was not possible to control such a crucial element as the capacity of the staff in the two periods. In the "after" period there was a different group of workers and a different number of them. Furthermore, the "after" period was not an entirely pure "after" period. Among the 1960 closed cases read, 8 of the long-type cases had been active continuously since before the data collection period started. Therefore the precision with which final judgments could be made on the effectiveness of the case assignment plan was seriously affected.

A test of interjudge reliability would have been important. Such a test was not employed because the samples used for each period in each pretest by the two readers were small—from 5 to 10 cases during each pretest. The absence of a test for interjudge reliability was compensated for by using in the final sample only those cases on which the degree of agreement of the two case readers met a defined standard.

There were also complications ensuing from the fact that the research was conducted by the department head, although efforts were made to compensate for possible difficulties in terms of subjectivity, reactions of staff, role problems, availability, and gaps in the project director's research experience.

SUMMARY

In summary, this paper is concerned with a study in a hospital social service department which introduced a new method of assigning cases at various levels of skill. The research was aimed at exploring whether this method serves patients and their families as well or better than the traditional method and conserves professional time appropriately. The method and the criteria for its application were discussed, as well as three approaches in evaluating results: from the points of view of quantity and quality of service and from the point of view of staff reaction. It is hoped that if the case assignment method in this study is proved to be effective in promoting better utilization of social work manpower, the method may have applicability to other hospital casework departments, and possibly, with modifications, to other kinds of casework agencies.

BY CARL S. HARM AND JOSEPH GOLDEN

Group Worker's Role in Guiding Social Process in a Medical Institution

THE PURPOSE OF this paper is to apply social system theory to understanding the guidance of social process in a medical institution, with special emphasis on the role of the group worker. A brief description of the agency as a social system will be given, followed by an analysis of the role of the program worker in the acute ward. The institution is Irvington House in Irvington, New York, a private, nonprofit agency whose primary purpose is the treatment of boys and girls, ages 6 to 16 and older, who suffer from rheumatic fever. It is hoped that the fruitfulness of certain concepts will be demonstrated by their application to some aspects of the agency's work.

Whether an institution is referred to as a therapeutic community, a small society, or a social system, the same point is brought out: that it is a little world of its own with its own routines, customs, and ways of living, and that the client (patient or resident) is affected in many ways by the life of this little world—not only by the kind of direct treatment provided. A social system may be understood as a system of roles, functioning to achieve certain goals, based upon a set of values both expressed and unexpressed. Within the over-all social system of the institution subsystems exist, such as the "acute ward" in Irvington House.

Roles are based upon the internalization by persons occupying status role positions of the same values that are institutionalized in the social system. To quote Parsons: " . . . a role is the organized system of participation of an individual in a social system with special reference to the organization of that social system as a collectivity. Roles, looked at in this way, constitute the primary focus of the articulation and hence interpretation between personalities and social system." [1]

> Role performance by an individual is always interdependent on the role performance of others, hence upon role expectations. Status or social position is equivalent to an organized system of role expectations. . . . Two general kinds of expectations are found: rights and obligations. Rights are role expectations in which the actor of the role anticipates certain performances from the actor of the reciprocal role. . . . Obligations (or duties) are role expectations in which the actor of a role anticipates certain performances [of his own] directed

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[1] Talcott Parsons, "Definitions of Health and Illness in the Light of American Values and Social Structure," in E. Gartly Jaco, ed., *Patients, Physicians, and Illness* (Glencoe, Ill.: The Free Press, 1958), p. 167.

toward the actor of the reciprocal role. . . .[2]

VALUES, ROLE STRUCTURE GOALS

An official expression of the Irvington House value system[3] reads as follows:

> Irvington is . . . a specialty hospital. . . . A major concern . . . is the "whole child." This concept simply means that our patients who are children like other children, with all the same problems, plus the additional difficulties brought about by their disease, require much more than just medical care. The hospitalization period, the separation from home and family, and the adjustment to living in a communal group—all these are special problems of our children.[4]

And again:

> Although the agency's major function is medical. . . . We take it as axiomatic that "the whole child approach" must be carried out by the "whole situation." In our practice, however, this involves something different from what is usually referred to as "teamwork." When the word "team" is used in a medical setting, generally it is implied that the doctor is the captain of the team and that the other professional disciplines, nursing, teaching, group work, etc. play subordinate roles. In our theory and practice, no one of the professional disciplines is superior and no one is subordinate.[5]

The role structure of the agency provides for twelve program workers who work in the various wards; only these are nonprofessionals, although some second-year social work students function in this capacity in block field work assignment. The program director, who reports directly to the agency executive, is a professional group worker; he is in charge of the work of the program workers. The assistant program director, also a professional group worker, and the program director supervise the program workers. The medical director is a doctor; the agency executive, or executive director, is a professional social worker. The social services director is a caseworker with three other caseworkers on her staff. Thus the role structure is such as to give a strategic place to social treatment. Although barriers to communication and power struggles are likely if not inevitable in role structures in which members of one profession[6] are supervised by or report primarily to superiors of another profession, this danger may be minimized in the kind of social system outlined above, both by the role structure and the value philosophy.

The child's total participation in the Irvington social system may be seen from the social system frame of reference as *never "neutral"* in its consequences, but as necessarily either positive or negative because of role performance and role learnings. The child emerges from Irvington, it is hoped, both physically and socially improved. In other words the goal of treatment is both physical improvement and improvement in social functioning. The latter goal is at least implicit even in the case of complete physical recovery—in fact it is doubtful if complete physical recovery is possible without it. Help in social functioning or social treatment is obviously of special importance in the cases of those who suffer from some long-term or permanent impairment of function, particularly of the heart.

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[2] Theodore R. Sarbin, "Role Theory," in Gardner Lindzey, ed., *Handbook of Social Psychology* (Cambridge, Mass.: Addison-Wesley Publishing Co., 1954), Vol. 1, p. 226.

[3] The phrase "value system" is a social system concept; it is not used in the Irvington statement.

[4] Mrs. William J. Oppenheim, "Orientation to the 'Whole Child' Approach," in "Irvington Conference on Readiness and Responsibility," p. 22. (Mimeographed, no date.)

[5] Joseph B. Gavrin, Executive Director, Irvington House, "Child Care and Social Service at Irvington House," *ibid.*, p. 25.

[6] Each profession ascribes to itself a certain status, which indicates its location in a hierarchy of professions, as well as a role, which indicates how members of that profession are expected to behave.

For the sake of clarity, social treatment will be defined here as all activity directed toward helping the client to develop adequacy, or better than adequacy, in the performance of social roles. Lest it be thought that this ignores the psychological factors, it is important to point out that roles may not be performed adequately without internalization by the self. To quote Sarbin:

> There is structure within the organism and structure within the environment. It is to the investigation of these structures and their interaction that role theory addresses itself. In broad perspective, contemporary role theory regards human conduct as the product of the interaction of self and role. Not dissimilar is Parsons' and Shils' idea of need dispositions and role expectations.[7]

Personalities *interpenetrate* with social system through roles.[8]

THE ACUTE WARD

The acute ward in our frame of reference is a social system, or subsystem, within the larger social system of the institution.

Every client (child patient) is first assigned to the acute ward upon entrance to the agency. In practically all cases the patient has already recognized himself as a sick person even before admission. To use Parsons' conceptualization, the child is involved in the "social role of illness" and is occupying the "role of the sick person."[9] The "deviant behavior" of the one playing this role is subjected to "a mechanism of social control—primarily by directing the passive deviance of illness into closely supervised medical channels. . . ."[10] The sick person is excused from the usual demands and responsibilities of society by medical authority. Implicit in the "sick person" role is the danger of the patient settling down in the role in a sort of permanent or long-term regression. "A primary aspect of the process of social control . . . consists in the transformation of this key object (the patient) from predominance of the 'deviant' role to that of the 'conforming' one."[11]

The "conforming role," of course, is one of normal social functioning in accordance with the person's age, sex, and so on —in other words, the person's status or social position in the larger social system outside of the hospital. As Parsons points out, the sick role is only conditionally and partially legitimized or accepted in our society. "That is, if a person is defined as sick, his failure to perform his normal functions is 'not his fault' and he is accorded the right to exemption and care. At one and the same time, however, the sick person is enjoined to accept the definition of his state as undesirable and the obligation to get well as expeditiously as possible."[12] Parsons, a sociologist, states what social workers understand: "Even in those instances where the *etiology* of the disorder is primarily physico-chemical, the nature and severity of symptoms and the rate of recovery are almost invariably influenced by the attitudes of the patients."[13] Hence the importance of the social treatment of the patient in the acute ward.

The program worker is in the acute ward during the part of the day when the children are not involved in schoolwork under supervision of teachers or asleep for the night; the program worker's hours are 3 P.M. to 10 P.M. on weekdays, with different hours on Saturday and Sunday. Girls and boys are in separate wards; though the number in each ward varies from time to

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[7] Sarbin, *op. cit.*, p. 223.

[8] *See* Talcott Parsons and Robert F. Bales, *Family, Socialization and Interaction Process* (Glencoe, Ill.: The Free Press, 1955).

[9] Talcott Parsons, *The Social System* (Glencoe, Ill.: The Free Press, 1951), Chaps. 7, 9.

[10] Talcott Parsons, "Illness, Therapy and the Urban American Family," in Jaco, *op. cit.*, p. 245.

[11] Parsons and Bales, *op. cit.*, p. 58.

[12] Parsons, "Illness, Therapy and the Urban American Family," *op. cit.*, p. 236.

[13] *Ibid.*, p. 237.

time, it always constitutes a small group, rarely exceeding twelve in number. Patients may be discharged from the acute ward, but usually are "graduated" to the ambulatory ward. The length of time in the acute ward varies greatly according to the individual case, ranging from two weeks to two months or more. Under these circumstances the guidance of group process is complicated, but there is a group with which to work.

WORKER'S ROLE: HELPING PATIENT PARTICIPATE

We see the function of the program worker as that of training the child through social treatment in his role as an Irvington client; any auxiliary "medical" activities of the worker we consider part of the social treatment function. The role-training of the child may be summarized as guiding him through social interaction to become a participant in his own recovery or partial recovery.[14]

The patient's role may be broken down into several aspects or subroles for the sake of clarity. The worker's role—helping the patient to participate in his own recovery—will be illustrated in connection with each of the four subroles of the client. Record material from a student's thesis will be used to show how the program worker carries on "role-training" of the patient in the acute ward.[15]

Patient's subrole No. 1. Upon entering Irvington House, he must come to terms with his anxieties, guilt feelings and ambivalences over his separation from his usual home (i.e., his entire round of daily activities in accustomed surroundings in and out of the family) *and family roles, and must adjust to a new situation. If he comes from another hospital, then too he has a new role to learn, since Irvington is different and he may have unresolved anxieties over separation from home, the other institution, or both.*

The first excerpt describes events in L's first day in the ward.

> . . . She was a very frail-looking, well-dressed child (age 6) who looked extremely frightened. . . . At bedtime L asked worker to hear her prayers. It was at this time that L expressed her fear and hurt. She said, "Dear God, I don't know what I have done to deserve this, but if you please help me to get well so I can go home, I'll be good."

It is clear from the record that the worker provided a secure relationship for the child:

> . . . even though L resented having to be away from her home, she was nevertheless very acceptive of worker and saw her as being the adult who took over some of her mother's duties. Each night before L went to sleep, she would wait for worker to come and listen to her prayers and tuck her in bed.

P's first reaction to the ward and the worker's response may be seen in the following:

> She was a very shy girl and extremely unhappy about having to come here. She cried for about thirty minutes after the social worker [caseworker] left the ward. Worker took her into the workshop to show her around. P was fascinated by all the models on display. P did not cry any more that day, nor the day after.

Patient's subrole No. 2. He must handle his anxieties over this physical condition, his fear of death or of permanent impairment, and incorporate the agency's opti-

[14] "Attention should be given to helping the adolescent find a role as patient which reinforces his worth through appropriate participation in his total treatment." From *Medical Social Work, Preparation and Performance,* sponsored by the Medical Social Division of the National Foundation for Infantile Paralysis (New York: The National Foundation, 1957), p. 24.

[15] Marjorie Anita Alexander, "The Use of Program Activity in the Adjustment of Children with Rheumatic Disorders." Unpublished master's thesis, Atlanta University School of Social Work, 1958.

mistic expectations of physical and social improvement as the end-product of the hospital experience; toward this end he must accept the medical regimen with its restrictive rules and regulations.

. . . Worker had spoken to D about keeping her bedrest status, and D had told worker that she had no intentions of staying on her bed. Worker asked, "Why?" D replied with remarks to the effect that she did not feel the need; she said that she was sick and did not feel as if she were ever going to get well. Worker asked her why she had taken this attitude. She said that when she was in the other hospital (referring to a New York City hospital from which she was referred), they (the doctors) told her mother that she had a "big heart" (enlarged heart) and that they wanted to perform an operation for which her mother would not sign. . . . Worker said in reference to the comment made regarding the operation, that she did not feel D should worry about that since the doctors here at Irvington House had not recommended an operation.

P was brought into close contact and interaction with other members of the group through her participation in certain group activities which brought her more toward the center of the group. The group, or part of it, influenced her toward a positive attitude to the medical regimen. . . . P had some idea of what being on yellow card meant, as she gathered from other children.[16] Therefore she was very happy her doctor put her on yellow card. . . . P seemed to have realized this meant a step closer to home.

Patient's subrole No. 3. He must learn to interact constructively with the other children in the ward and with the staff occupying the roles of doctor, nurse, caseworker, program worker, and so on. He must accept the hospital's image of itself as a place of recovery in which the medical treatment is viewed as a co-operative, joint endeavor by hospital personnel and the patient, aimed at this movement toward health.

Several records exhibit the ways in which the worker promoted interaction between the client and other children in the ward.

X was a child of superior intellect. . . . X found these girls in the ward dull and uninteresting in terms of presenting a challenge to her, as evidenced in her attempt to play such games as Monopoly with her peers. Her moves were much more mature and rational. . . . As a result, she gained prestige among them, but the attitude was not a reciprocal one, for she realized how much further advanced she was than they. Then, too, some of her peers recognized this and resented it. The activity of storytelling was one that afforded complementary roles for both X and her peers. [This situation was structured by the worker.] On occasion X was allowed to read a story to them, or to tell a story, one which they enjoyed very much. They were given the same opportunity, but because X was the superior storyteller, they invariably expected X to tell the story.

H was helped in her relationship with her doctor.

. . . H expressed a desire to give a dinner for her doctor. Worker thought this a good idea since H felt very close to her doctor and wanted to do something to show her appreciation (H's doctor was devoted to her and often made goodies for her). H took quite a bit of responsibility for planning and carrying out this program.

Patient's subrole No. 4. He must accept the next move—usually from the acute ward to the ambulatory ward, although sometimes to his home.

The move from the acute ward to the ambulatory ward is a step forward in recovery, but may be rejected emotionally by the child. The acute ward group in-

[16] Yellow card status means that the patient is ready for transfer to the ambulatory ward and is permitted increased mobility; this status is a trial period before transfer.

fluences may be negative as well as positive,[17] and the program worker must be aware of this. To quote the record:

> F was a member of a subgrouping . . . the leader of which was E, the oldest child in the ward, to whom all the children looked for guidance and leadership, which was very often negative as well as positive. F was greatly influenced by E. . . . F had been giving her parents and her social worker [caseworker] a considerable amount of trouble by refusing to go to "Ambu" even though she was medically ready to go. When told by her social worker that she would be moving soon, F threw a tantrum, influenced by E, who was also rejecting the idea. Worker withdrew F from the group. Worker discovered that when taken from the presence of the group, especially E, F did not really reject the idea.
>
> P was to be in the acute ward for a shorter period of time than most of the children; therefore worker attempted to prepare for the move to the ambulatory ward. Worker took P down to Ambu on several occasions in order to introduce her to some of the children and to the workers.

Concepts from role theory may be useful here. There is the ever present danger of the client solving the problem of *role conflict* between his sick person role and his normal role by the seductive process of yielding completely to passive dependency. There is the possibility of *role confusion* contributing to this seduction if the program worker is only permissive-supportive and does not also exert pressure toward recovery. There is the problem of *role discontinuity:* the client must move from the more or less normal social functioning role, and within the hospital usually from the acute ward role to the ambulatory ward role. Although space does not permit elaboration, it should be clear that the role performance of the Irvington House patient is fraught with difficulties.

It should be pointed out here that this statement of the client's role includes both "internal" or "inside," and "external" or "outside"—both covert and overt—behavior. "Invisible" feelings and attitudes, internalization of role by self, as well as "visible" role performances are involved.

The program worker's position in the role structure is strategic, because of her daily presence and social interaction with the child. Again referring to Parsons' conceptualization:

> Analysis of processes of social control has shown that those who play a strategic part in such processes as agents of control must play at least a dual role. They must to some important degree participate with the "deviant" (*e.g.*, the sick person) in at least a limited way "on his own terms." They must, that is to say, be authentically parts of a deviant subsystem of interaction. But at the same time they must also play an authentic role in the wider system relative to which the sub-system is defined as deviant; the physician [or program worker] is not himself "sick" but "represents" the society of the non-sick in his interaction with his patients.[18]

The relationship of the program worker with the patient may be used as a sort of bridge between the deviant subsystem and the superordinate system. Once the client forms a positive relationship or attachment to the worker, the latter may use his other role "as in some sense defining a 'model' for the child to emulate and as a basis for 'leverage.' " [19]

In guiding the role performance of the patient, the group worker must be permissive-supportive, on the one hand, but

[17] Cf. Kirson Weinberg, "Organization, Personnel, and Functions of State and Private Mental Hospitals: A Comparative Analysis," in Jaco, *op. cit.*, pp. 478–491. *See also* Morris S. Schwartz, "Social Research in the Mental Hospital," in Arnold M. Rose, ed., *Mental Health and Mental Disorder* (New York: W. W. Norton & Co., 1955), pp. 190–202.

[18] Parsons and Bales, *op. cit.*, p. 58.

[19] *Ibid.*, p. 59.

"pushing" (even "needling") and "stimulating" on the other hand. The client must be permitted some dependency in his sick role, but must not be allowed to settle down to long-term or permanent regression, passivity, or invalidism; must be encouraged to work toward maximum possible recovery or optimum social functioning.

In the record excerpts quoted we can see overt role acts of the worker directed at the guidance of the patient's role performance—participation in his own recovery. No effort will be made here to categorize the worker's role acts in terms of assessment followed by support, interpretation, guidance of interpersonal relating and relationships, and program activities. However, it seems clear, even without further analysis, that such a categorization would consist of types of acts carried out in relation to, or as a way of, performance of the worker's function of helping the patient to perform his role in the social system of the institution.[20] While there is no intention here to argue the superiority of the group worker's role, there is no role incumbent on the treatment staff who is in an equally advantageous position to influence constructively the day-to-day, hour-to-hour functioning of the patient.

The group worker's role is not unique in its purpose; within the institution the doctors, nurses, teachers, and caseworkers are each concerned with all or some of the same four subroles of the patient. The uniqueness of the group worker's role lies in his exceptional opportunity to guide interaction because of his place in the social system where he is more a part of the group living situation—the "deviant subsystem of interaction"—than any other role incumbent on the treatment staff. This is true not only because of the presence of the group worker in the group situation for a greater amount of time than any other role incumbent, but also because of role definition of the group worker's position by the agency. Although the agency does not conceptualize his role in terms of social system theory, in effect the definition of the worker's role is not inconsistent with the idea that he is the social interaction expert within the subsystem, acute ward, and within the social system, the agency as a whole.[21]

SOME GENERAL ISSUES

It is not within the scope of this paper to deal with the entire question of the application of group work method, or the use of group workers in a medical setting or institutions of different kinds. However, a few points will be made, because of the inevitable implications of the material presented and because of our concern with the use of the group process.

First, it is well to point out some general advantages in seeing the guidance of group process within the frame of reference of the institution as a social system. Illness is conceptualized not as an entity existing within the individual's organism, but as a physical-psychosocial disturbance which affects the social functioning or role performance of the person. The hospital role of the sick person is then seen not as necessitating the passive acceptance of physical treatment, but rather as one of participation in recovery, a process requiring the guidance of the social interaction of the patient and patient groups. The social process of the hospital, and the patient's participation in it, can be therapeutic or antitherapeutic. The entire staff of the institution—professional and nonprofessional—affects the condition of the client. Communication breakdowns within the staff (*e.g.*, between different staff roles or ideologies) may be antitherapeutic, as

[20] Cf. the discussion by William Schwartz of the group worker's role in "Group Work and the Social Scene," *Issues in American Social Work*, Alfred J. Kahn, ed. (New York: Columbia University Press, 1959), pp. 110–137.

[21] The scope of the present paper does not make possible the analysis of the ramifications of the worker's role throughout the social system.

pointed out by Schwartz and Stanton and others.[22] Hence the social worker, whether group worker or caseworker, needs to understand the entire social system, not just his direct service or other immediate responsibilities.

Although many program activities are planned for the "leisure time" of the patients, the program worker's role cannot be stated in terms of guidance of a formed or "natural" leisure-time group. The role is rather that of a guide of, and participant in, a group living situation in which the group is not formed to carry out leisure-time pursuits, is not voluntary, and is not self-constituted. This calls for the guidance of group process, or the social interaction of the ward group as a social system or subsystem within the over-all system of the agency.

Individualization is crucial. However, it can be done successfully only within and with an awareness of the context of social interaction. What affects one patient as a member of the ward social system directly or indirectly affects all or several others, not only obviously but sometimes almost explosively. This situation does not permit concentration on the individual psyche apart from social relationships. The "payoff" of the program worker's work is always, and clearly: How does it contribute to role performance of the child in the ward and in the institution as a whole? Ultimately the patient is no more cured by the doctor of the institution than the student is educated by the educator or the educational institution. The teacher helps the student educate himself; the group worker helps the patient's self-recovery through guidance of his role performance in the social interactional "field" of the ward and the institution.

It seems clear that the role of the program worker is essential to the fulfillment of the objectives of the agency, and equally clear that this role may be best performed, or at any rate supervised, by social workers educated in the understanding of group process and use of group skills.

In institutions generally, whether medical, psychiatric, correctional, or other, it is a truism that the client cannot be stored away in some sort of social vacuum between sessions with the doctor, psychiatrist, or caseworker. The role performance of the client in the social system that prevails between such sessions is also treatment in its consequences, whether or not it is recognized as such and dealt with accordingly. And the acceptance and use by the patient of the direct treatment is part of his overall role performance in the social system, and not simply a function of his relationship to the direct treatment and the person carrying out that role.

It is hoped that the above analysis suggests the fruitfulness of social system theory for both research and practice in the guidance of social process in the institution.

[22] A. H. Stanton and M. S. Schwartz, *The Mental Hospital* (New York: Basic Books, 1954).

BY MAX SIPORIN

Private Practice of Social Work: Functional Roles and Social Control

THE NASW COMMISSION on Social Work Practice has viewed the private practice of social work as "falling within the present definition of social work practice."[1] Such an act of legitimation, along with our greater clarity about the nature of social work itself, should enable us to make a fresh and empirical examination of this rapidly growing baby in the social work family. We may now be in a better position to describe the infant's characteristics, discover its developmental needs, and provide it with proper nourishment, support, and structure. This paper will examine the social institutional aspects of social work private practice and its functional roles, particularly as an instrument and mechanism of social control.[2] We shall also consider some of the implications of the development of private practice for society and for the social work profession.

It is suggested here that the independent practice of social work has many of the same societal functions that are carried by social work agency practice. Private practice is part of the multifarious, complex fabric of social work as a social institution. Whether in agency or private settings, social work as an institution is concerned with the diagnosis, treatment, and prevention of social dysfunction, maladjustment, and dependency—or, to use a more general term, of social deviation.[3] Social work is society's own re-equilibrating influence in regard to deviant behavior. In this respect its services to individuals and groups are adjustive, therapeutic, and restorative. In discharging these functions a major purpose of social work is to serve and maintain the social welfare services.[4]

The present structure of social welfare services in this country aims at insuring and maintaining adequate standards of living and of social functioning and adaptation for all. It is important to recognize that the social welfare system has a private and a public structure, which are roughly parallel —interdependent, but with wide gaps between. There is an extensive private apparatus of welfare devices, which has developed to meet the need for individualized and intensive services on the part of status groups in our urban, complicated, specialized society. Such a welfare apparatus particularly aims to serve the needs of middle- and upper-class groups. It is made avail-

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[1] *NASW News,* Vol. 4, No. 3 (May 1959), pp. 2–3.

[2] For an earlier effort to relate social work to social control functions, *see* Robert K. Taylor, "The Social Control Function in Casework," *Social Casework,* Vol. 39, No. 1 (January 1958), pp. 17–21.

[3] Talcott Parsons gives a twofold definition of deviance: as a motivated tendency for a person to behave in contravention of institutionalized normative patterns, and through which the group member or members disturb the equilibrium of a social system. He defines social control as those tendencies that counteract deviance and result in the re-equilibration of a social system. *The Social System* (Glencoe, Ill.: The Free Press, 1951), p. 250. In this work (pp. 312–321 and 428–479), Parsons gives a relevant analysis of medical practice as a "mechanism of social control."

[4] Alfred J. Kahn, "The Function of Social Work in the Modern World," in *Issues in American Social Work,* edited by the author (New York: Columbia University Press, 1959), pp. 28–33.

able through private and fee-paid types of activities, through voluntary associations, and private banking and insurance; through educational, church, legal, medical, and other services.[5] The development of fee services and of private practice in social work extends the contribution of social work purposes, methods, and philosophy to the private welfare structure of our society. This development also represents social work's assumption of its proper institutional functions, not only for the poor, but for the whole community.[6]

The institutional tasks of social work in serving social welfare needs are discharged essentially by its professional personnel. They are completed through the functional roles of the social work practitioner, whether active in an agency or in a private practice setting. We can observe this by an examination of several significant roles carried by social workers. The emphasis will be on the aspects of social control in these roles as they are illustrated in private practice. Almost all the roles noted here are therapeutic. No attempt will be made to cover the extensive range and variety of social worker roles or to treat them systematically.

SOCIAL WORK COMMUNITY ROLES

There is one general community role which, one may say, social workers carry as part of their characteristic social identity. This is their role as *social parent*. Such a social identity is expressed in the general public image of social workers as members of an altruistic, accepting, tolerant professional group that helps people in trouble.[7] Social work clients are usually unloved, neglected, deserted by, or alienated or outcast from, their family groups. Social workers take the place of incapacitated or absent parents; they supply needed parental nurture, support, insulation, and love. They thus help people resume their place in, and belong to, some family or social group again.

Our role of social parenthood is different from that of parental roles enacted by other professional disciplines. The social worker clearly represents both the community and the individual, and he does so in a nonpunitive, nonmoralistic, and professionally self-disciplined way. The social worker's main job (rather than a by-product of it) is to help the individual return to a more effective and satisfying functioning in his family, work, and other social roles and situations.

It is as a social parent that the social worker does the therapeutic job of emotional healing, of ego repair, of helping individuals through the traumas of frustration, deprivation, disappointment, and moral transgression. He serves as an ego ideal and superego model for identification and for internalization of the community's normative values, goals, and role expectations. He teaches role skills. He thus aids in the development, maturation, and integration of personality. He gives or denies material things and resources. Social parenthood constitutes an essential factor in the social worker's therapeutic influence, since this role concept in itself is a very important symbolic source of the worker's ability to meet the client's expectations for relief of his suffering and distress. It enables the client to commit his trust and faith to the worker, and this commitment in turn, through the assumption of the client role, becomes an important force in the therapeutic process.

[5] Private and fee services generally give to the buyer the choice of an individual practitioner and a claim to his expert skill. It is suggested that private practice, as distinguished from fee practice, is consistent with the socialization of social work, should this ever be desired.

[6] It is of interest that Mary Richmond recorded the existence, before 1917, of a demand for private casework service. *See Social Diagnosis* (New York: Russell Sage Foundation, 1917), p. 27.

[7] Margaret B. Bailey, "Community Orientations Toward Social Casework," *Social Work*, Vol. 4, No. 3 (July 1959), pp. 60–66; Erma T. Meyerson, "The Social Work Image or Self-Image," *Social Work*, Vol. 4, No. 3 (July 1959), pp. 67–71.

There are two roles subsumed in that of the social parent, which can be described briefly here. The social worker is characteristically a *group leader*. Even when working with one person, he is habitually treating his client's social situation and social system as a social work way of helping. He enters, participates, and becomes a leading member, directly or symbolically, in the client's family and social group. Whether in casework or group therapy, he uses and treats group organizational structure and group functional processes. He sees family members individually or together, or provides substitute family groups, as well as new reference groups, through which to offer new cultural frames of reference and thus effect or facilitate change.

The social worker also functions as a *community caretaker*. Thus the social worker is regarded as one of the "safeguarding, caretaking agents of the community," and one "who tends to be called upon when individuals meet psychologically stressful situations," in order to handle deviant behavior on behalf of the community and of individual emotional and social health.[8]

Although the social worker represents the interests of the community and acts as an instrument of social control, he also acts as an instrument of social change. He does so as a *social reformer*. The outward clothing and forms of expression may have changed, but the reform heritage in social work has been a living one, and the tradition has shown renewed vigor in recent years. The social worker generally has maintained a liberalistic, democratic, and humanitarian social philosophy and a strong sense of social obligation. He has continued to be in the forefront of movements for social legislation, acting as a potent influence in shaping social policy and to extend the public welfare concept in American society.[9] It would appear that many social workers also still regard the old-time crusader and social reformer as their professional ego ideal.[10] To realize such a function, the private practitioner can be active as a *community organizer* in stirring up public sentiment and opinion, as well as through participation and leadership in community council and other community associations, to help develop and improve welfare services.

We can only mention two additional roles here. One is that of *educator*, which for the private practitioner involves activity in teaching institutes and in-service training programs, in student training through part-time agency positions, and as part-time faculty in schools of social work. The social worker as *researcher* is still a potential role for the general social work practitioner, and a professional superego seems to be developing in this direction.

SITUATIONAL ROLES

We turn now to a number of situational roles which are habitually performed by social workers as they play their "parts" in the transactional social situations of their clients. In enacting them, the social worker's perspective is characteristically a situational one. A social situation may be understood as a social group focalized in action at a certain time and place around a stressful issue.[11] Social workers help people with social situations that are disturbed, disordered, stressful, or conflicted, and which are usually defined as crisis situations. Social workers are therefore also concerned with the maintenance, modification, and

[8] Robert H. Felix, "The Strategy of Community Mental Health Work," *The Elements of a Community Mental Health Program* (New York: Milbank Memorial Fund, 1956), pp. 44–46; Gerald Caplan, "The Role of the Social Worker in Preventive Psychiatry," *Medical Social Work*, Vol. 4, No. 4 (September 1955), p. 153.

[9] Bertram M. Beck, "Shaping America's Social Welfare Policy," in Kahn, ed., *op. cit.*, pp. 206–207.

[10] For an excellent image of the social worker as social reformer, *see* Edward T. Devine, *When Social Work Was Young* (New York: The Macmillan Company, 1939), pp. 149–158.

[11] James H. S. Bossard and Eleanor S. Boll, *Sociology of Child Development* (3d ed.; New York: Harper & Brothers, 1960), pp. 3–26, give an excellent statement of a situational approach. *See also* Ada Eliot Sheffield, *Social Insight in Case Situations* (New York: Appleton-Century, 1937).

control of situational definitions, made by the individual performers, by the performing group, or by the surrounding community audience.[12]

In assisting people with their social situations, the social worker generally functions as a *service specialist.* He offers a highly specialized, professionalized service, as in the "construction, repair and maintenance of the show that clients maintain before other people." [13] By "show," we refer to the dramas of life, the personality impressions, and the social role performances of our client-actors. These service specialists are like parents in that they learn secret and often destructive information about their children or clients and also obtain a backstage view of the situation. For the social worker, this information and perspective enable him to arrive at a more accurate diagnosis and to achieve a professionally powerful and superordinate position through which to exert his influence for therapeutic objectives.

One of the more important roles performed by social workers is that of the *trouble-shooter.* Private practice underlines the realization that this is a social worker's specific function and unique contribution in regard to many kinds of problems. Thus the social worker is "an expert in trouble," with unusual competence in coping with and helping to resolve crisis social situations. People generally contend with difficulties on their own, or seek help from family members or friends, but some situations become completely tangled and disorganized. Then they come to, or are referred to, the social worker. He is expected calmly, dispassionately, professionally, and competently to provide social and emotional first aid; to diagnose the trouble, unsnarl the mess, and set the situation right. Part of this function involves being a *fixer.* We may observe that the social worker has increasingly taken the place of the old-time saloon-keeper, ward politician, minister, or priest as a community agent in providing this function for many people in trouble.

> A husband came for help because his wife had filed for divorce, after seeing him out with another woman. Both husband and wife had felt neglected by each other; the husband had sought financial success and the wife had been left alone to rear four small children. Both were helped to understand each other differently, to reconcile, and then to assume more reciprocal spousal roles.
>
> A young adolescent was brought in by his parents, who complained that he would not study, though he was of superior intelligence and could easily realize their ambitions for him. The boy responded to the encouragement of the worker that he strive to realize his own desires, while the parents were helped to work out their conflicted relationship.

A related role is that of the *contact man.* The social worker is increasingly regarded as one who, in varying degrees, knows his way around through the vast, amorphous structure of community power and social resources and facilities, both public and private. Wilensky and Lebeaux define this role well.

> The growth in scale and complexity of social organizations . . . creates a demand for liaison and contact men of all kinds. We need guides, so to speak, through a new kind of civilized jungle. Social work is an example par excellence of this liaison function, a large part of its total activity being devoted to putting people in touch with community resources they need but can hardly name, let alone locate.[14]

[12] For an analysis of the management of situational definitions, *see* Erving Goffman, *The Presentation of Self in Everyday Life* (New York: Anchor Books, 1959). Three of the role types discussed below (the service specialist, mediator, and confidant) are adapted from his chapter on "Discrepant Roles," pp. 141–166. A basic study of group roles is given by K. D. Benne and P. Sheats, "Functional Roles of Group Members," *Journal of Social Issues,* Vol. 4 (1948), pp. 41–50.

[13] Goffman, *op. cit.,* p. 153.

[14] Harold L. Wilensky and Charles N. Lebeaux, *Industrial Society and Social Welfare* (New York: Russell Sage Foundation, 1958), p. 286.

The private practitioner gets many inquiries about his services and does a good deal of referral, particularly to social agencies. Sometimes his services are sought specifically as a contact man.

> A mother came about her 14-year-old son, who had been picked up by the police because of his involvement in gang vandalism. She wanted him extricated and she also wanted help with him. The police and juvenile authorities dropped the charges against the youngster, on assurance that the father would pay for the damage done and that the parents and the boy would enter treatment. The three placed themselves in treatment.

To implement the above activity, the social worker often serves as a *co-ordinator.* Social workers have a specific skill in the use, integration, and co-ordination of community and institutional resources, with the objective of meeting the total needs of an individual client or family group. As experts in working with people, social workers also are highly skilled in colleague and conference relationships. Through such skills the worker achieves a group consensus whereby resource people commit themselves to helping the client or group. In this way social workers alter natural and social environments so as to modify their situational control over malfunctioning clients, and also to provide a more therapeutic milieu for more effective social adaptation. The worker, being in a pivotal position to provide and facilitate access to social resources, also serves as an *expediter.* Although the private practitioner is not able directly to supply a number of material resources, such as money, jobs, children, imprisonment, he is able to act as an expediter in relation to such resources, particularly in regard to nursing homes, employment agencies, special schools. Within the limits of his position, the worker also is obligated to help clients make maximum use of the resources chosen or provided as aids in the solution of problems.

As a participant and intervening force in social situations, the social worker frequently acts as a *mediator,* who may function as a *go-between, mouthpiece, buffer,* or *referee* for the individual and the family or other primary group, as well as for the community. He strives to be loyal and neutral to all sides, impartially representing each side in facilitating communication and understanding, relieving tension, and redefining personality impressions and situations. When indicated, he presses for compromise, negotiation, reconciliation, and mutually rewarding agreements which will resolve role and interpersonal conflicts and re-establish group order and equilibrium. One of the social worker's strengths as a mediator is his skill in the involvement of family and other social groups, and in the structuring of therapeutic roles for the group members so that they may "help" the focal individuals who have become "sick" or incapacitated. The role of mediator is particularly operative in marital and parent-child conflict situations, in regard to juvenile gang relations, and in legal and hospital situations.

> A psychiatrist referred the case of a youngster from a well-to-do family, who had been stealing compulsively and who was to be sent by the juvenile authorities to the state reformatory. At the worker's suggestion, and by negotiation with the juvenile workers, the parents, the youngster, and the psychiatrist, it was arranged for the boy to be placed in a residential treatment center. A specific recommendation was made to the court, the parents, and the psychiatrist that the parents place themselves in counseling.

As a mediator, the social worker often becomes a *confidant* to one or another party in a group conflict. "Confidants are persons to whom the performer confesses his sins." [15] The secular act of confession (for example, to a wish by a mother that she were rid of her children) is a way of relieving burdens of anxiety, guilt, and shame, and of regaining a supportive social contact and solidarity through another person. In addition:

[15] Goffman, *op. cit.,* p. 159.

> The confession is an act which involves admission of deviance from the controlling values or normative expectations of a given situation. . . . In admitting deviance, it supports and reasserts the supremacy of the existing value structure of the organization. It is an expression of ideological conformity.[16]

A crucial and instrumental role in problem-solution is that of the *guide* and *teacher*. Though a number of these responsibilities may be regarded as parental ones, several educational and guidance functions in casework, group work, or intergroup work have a special significance here.[17] In order to help in decision-making and in goal-achievement, the worker emphasizes and teaches specific knowledge, procedures, and technical skills in the concepts and performance of social types and roles.[18] He enables the client to gain awareness of role conflicts and to modify or reconstruct roles or learn new ones. He guides the individual and group through criteria and rules about what is right or wrong, normal or abnormal, appropriate or self-defeating, in the tasks of becoming a mature personality, of performing the part of the "good" husband, mother, or oldest son; of coping successfully with the dilemmas and challenges of life experience.

The worker enforces normative values and goals and discourages deviant motivations and behavior, within a range that is therapeutic. There is supervision, discipline, and the setting of limits, as well as reward and disapproval for poor or good learning. There is an orienting, reality-testing, and evaluating kind of guidance as well as encouragement, inspiration, and tension relief during the learning process. There is an exemplary presentation of the worker's self, or the use of "ideal types," as models for identification and role-learning. These elements of the therapeutic process are more characteristic of social work treatment procedures than the "insight" into ego-defensive mechanisms or "personality structure" so highly valued by other helping disciplines.

> A social worker referred her daughter, who was planning to marry, but was anxious and confused about this. The girl brought in her boy friend so that both could have help to clarify their feelings about each other and about their marriage plans. They asked for and were advised about the considerations involved in premarital sexual behavior.
>
> A wife brought in her unemployed, alcoholic, and somewhat paranoid husband. He was seen in long-term, intensive therapy, was helped to return to work and to assume more effective and satisfying husband and father roles. The wife was aided in becoming more accepting of her husband, to enter vocational training, and to move toward less dependent wife and mother roles.

The assistance given with stress and crisis situations naturally evokes the *innovator* in the social worker. Crisis situations involve people who are unable to resolve their problems through habitual problem-solving patterns; they are frequently demoralized and act "out of character." Such situations also involve the suspension of the social control mechanisms—the norms, values, and status relationships that regulate the structure and functioning of the group. Conditions of disorganization and demoralization therefore permit experimentation with new values, behavior, and role patterns. The social worker recognizes, supports, and legitimates

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[16] Lloyd Ohlin, "Conformity in American Society Today," *Social Work*, Vol. 3, No. 2 (April 1958), p. 65.

[17] Fritz Redl, "Strategy and Techniques of the Life Space Interview," *American Journal of Orthopsychiatry*, Vol. 29, No. 1 (January 1959), pp. 1–18, discusses similar roles of "tool salesmanship" and the "traffic cop." We should note that there are a number of other guidance roles for the social worker, in which there are more prominent socialization, adaptive, and integrative (rather than restorative) functions, such as in family life education and in certain forms of group work with children and adolescents.

[18] Max Siporin, "The Concept of Social Types in Casework Theory and Practice," *Social Casework*, Vol. 41, No. 5 (May 1960), pp. 234–242.

constructive deviation and innovation. He does this through new situational definitions, the supply of new resources, the teaching of new concepts and skills in social roles and types, and the creation of new family organizational and problem-solving patterns. The case examples given above illustrate this activity. The social worker in private practice cannot help but also be a stimulant and catalyst for constructive social change.

In the discussion thus far, a number of areas of social work competence have been described in which the social worker functions as an *expert*. In this role, the worker may act as a *consultant* in a variety of upset or crisis situations. He may contribute his diagnostic evaluations and recommendations for other social workers, or for related disciplines such as medicine, psychiatry, law, or industrial management.[19] The worker may issue a report, summarizing his social study, or he may issue certificates directly to clients for use with other community agents.

> A certificate was issued to a couple following the completion of an adoption study for an overseas social agency. This was done after discussion of this matter with the local child care agency which had refused this service. (This agency later changed its policy in regard to such requests).

> A client requested help to lower his payments to his ex-wife for child support, and if possible to help him gain custody of his children. A report was submitted to his attorney, and made part of the attorney's legal brief, recommending changes in the child support payments to stop the ex-wife's exploitation of this man. A change in custody was not recommended.

The social worker may also serve as an *expert witness* in courts of law.[20] This is a new development, fraught with many questions concerning the valid role and limitations of *expertise* in the courts.

It is apparent from the above discussion that these functional roles can be performed in private as well as in agency settings. Private practice permits a more varied type of case load and a greater independence and financial return than obtains generally in agency settings. Private practice does, however, require professionally trained, highly experienced, and highly qualified workers in order to have community sanction and support. The allocation of the societal functions carried by these roles—particularly their social control aspects—places upon the private social work practitioner an even greater responsibility for holding to his obligations as a social parent to serve both the individual and the social good.

SOCIAL CONTROL METHODS

One important source of difference between private and agency modes of practice is in the types of authority relationships used, and in the methods of social control. Both use formal and informal types of authority and control. The semipublic and public agencies are, however, legally licensed, incorporated, or directly empowered to employ various forms of formal or coercive sanctions and restraints. Social workers in agency settings therefore have a strong and clearly visible administrative as well as social authority. The private practitioner expresses some degree of social authority in his role as a social parent, which derives from the community's implicit arrangements with the social work profession.

[19] Consultation for social workers concerning problems of social work practice is a professionally anomalous affair. This is characterized by much dependence on external professional groups to give emotional support to the social work practitioner and to his supervisor. In part, this state of affairs has been a response to the lack of qualified social workers who could or would assume consultative and supportive functions to agency staff, and to self-depreciatory dependency tendencies exhibited by many social workers.

[20] Max Siporin, "Letter to the Editor," *Social Service Review*, Vol. 32, No. 1 (March 1958), pp. 72–73, recounts the author's experience as an expert witness in a court of law.

These arrangements may soon be made explicit through certification and licensing, by both the profession and the community. At this time, though, the authority relationship in private practice largely derives from the worker's role as a technical expert.

The influence of the private practitioner therefore depends heavily on informal and voluntary forms of authority and sanction. There is a characteristic social work attempt to help clients help themselves and to stimulate volition and self-motivation for change. There is a heavy reliance on the therapeutic relationship with the client and with his social or family group. In the private relationship, however, there is much more of a reciprocal power pattern than exists in agency practice. This involves a more mutual possibility of disapproval, withdrawal, or expulsion when there is a violation of mutual expectations or of the rules of the worker-client system. There seems to be a greater expectation that the worker will help actively, effectively, and with an authority the worker may not securely feel he has.

Recent social work theory has clarified the social worker's valid and constructive use of authority relationships.[21] Within the principle of client self-determination, social workers are learning to use the strength of their authority in order to help clients achieve the fragile integration and balance of conformity and creativity, autonomy and freedom. This balance, however difficult to attain in our society, remains a realistic objective for our helping efforts.

ROLE CONFLICT

Social work mediates the needs of the individual and of society. One of its basic assumptions is that the needs of society and of the individual are inherently complementary and compatible. The fact that they are actually often discrepant, and that the resulting problems are heavily infused with emotion, makes the role of the worker stressful and full of conflict. The nature and severity of these role conflicts are being increasingly recognized.[22]

The field of social work has set up an elaborate system of security mechanisms and of supervisory and consultative supports for the worker within the framework of social agency organization. This has evolved in order to help the worker contain his role conflicts, bear the burden of his anxieties and insecurities, preserve a professional neutrality and objectivity, and attain a positive, mature professional identity.[23] A prominent feature of this system is the confessional and therapeutic procedure of the supervisor-worker relationship (which now is being revised). In private practice this elaborate supportive, as well as protective and controlling, structure is lacking. The worker not only seeks his livelihood, but struggles unaided to achieve an autonomous, independent professional self.

Private social work practice therefore needs the help of the social work profession to create an appropriate security structure for it. In the process of creating this structure we may well recognize that the role conflicts of the social worker will always continue to operate to some degree, except in a Utopian society. Awareness and acceptance of this everlasting burden of stress should help to preserve social work's commitment to social change and social reform.

IMPLICATIONS FOR PROFESSIONAL STRUCTURE

There are a number of ways in which the needed security system for private practice

[21] Elliot Studt, "Worker-Client Authority Relationships in Social Work," *Social Work*, Vol. 4, No. 1 (January 1959), pp. 18–28.

[22] For example: Charlotte Babcock, "Social Work as Work," *Social Casework*, Vol. 34, No. 10 (December 1953), pp. 415–422; Wilensky and Lebeaux, *op. cit.*, pp. 317–325; Robert D. Vinter, "The Social Structure of Service," in Kahn, ed., *op. cit.*, pp. 247–264; Lydia Rapaport, "In Defense of Social Work," *Social Service Review*, Vol. 34, No. 1 (March 1960), pp. 67–74.

[23] Norman A. Polansky, "The Professional Identity in Social Work," in Kahn, ed., *op. cit.*, pp. 293–318.

can be established. One is to give every professional worker full legal, ethical, and professional responsibility for his clients and his practice. Inseparable from this is the need for a conscious professional self-image on the part of every worker as a social parent and "instrument of social control and social change." [24]

To accomplish these objectives, it is necessary that the worker assume and be granted a strong social authority, through community and professional sanction and support. This would require a strong code of ethics and a meaningful social philosophy nurtured and reinforced by the profession and the professional schools. It would also require legal licensing and professional certification. The certification of advanced competence necessary for private practice would also seem to require the diplomate and, in time, the doctorate status, to insure high standards. Grievance committees and adequately empowered regulatory boards within each NASW chapter are valid protective devices. We might consider the advisability of specifying, as a professional obligation, that every private practitioner have a responsible affiliation with a community social agency. Such an affiliation might be on a paid or voluntary basis. This would enable agencies to profit from the knowledge and experience of private practitioners, and enable private practitioners to gain the stimulation, the use of experimental and research laboratories, and the supportive organizational structure that the agencies can appropriately offer. Such measures would help to provide a needed security system for the private (and agency) practitioner, and support the worker in carrying out his functional roles as an authorized community and professional representative.

The development of private practice is bound to have profound effects on the profession and on social agency organizations. Though the vast majority of social workers may continue to work in agency settings, the concrete possibility of private practice affords an opportunity—as well as a safety valve—for social workers who at present move from one job to another in search of such goals as security, adequate financial returns, prestige, and independence. Private practice should help to reduce the high turnover rate that plagues agency personnel situations, and should therefore encourage the greater degree of stability requisite for effective agency service. The existence of a body of highly qualified workers who are committed to practice rather than to administrative status struggles should also encourage high standards of training, research, and service.

We have focused a good deal on the institutional, social control functions of the social worker's roles. It is again important to emphasize the constructive aspects of these control functions and their positive contribution to the social competence and welfare of the individual and of his family and other social groups. Here is a potent force for an appropriate approach to the problems of social disorganization and deviance, of social maladjustment and dependency.

Private practice fills an institutional gap in meeting the pressures for social work service from an important and large segment of the community. It extends and realizes social work's purpose as an institution to serve the interests of the total community, and marks the attainment of professional maturity and status. Its contributions bring certain problems to which the profession has already begun to address itself. As an instrument for social control and change, the social worker, in private as well as in agency practice, needs to carry—and to be helped to carry—his obligations and mission with secure balance and with good will.

[24] Kermit T. Wiltse, "The Hopeless Family," *Social Work*, Vol. 4, No. 4 (October 1958), p. 19. Wiltse also emphasizes the "parenting responsibility" of the social worker's societal role.

BY ALEXANDER HERSH

Casework with Parents of Retarded Children

IT SEEMS TO be a sign of the times, a good omen perhaps, that most parents of retarded children are eager to have help for their child, and similarly, for themselves with their own feelings about the child. Like the remainder of the community, however, they feel the need to control the help they receive. They seek it when they want it, take as much or as little as they desire, and focus their use of help in areas which present the greatest concern to them, though these may not be the areas we see as most problematic. As a natural reaction against the intense and interminable quality of their problem, they frequently want to resolve their anxiety precipitously. They seek a simple or comfortable solution. One's first reaction might be to agree with them—agree that their problem is too great and their feelings should be spared. This attitude is a reflection of the feelings of the larger community, which finds the total impact too hard to bear and surrenders to it. This may be exemplified in the "put him away and forget about him" prescription.

These observations are offered because the writer believes that in developing service for the retarded and their parents, one must look at the degree of parental and community responsibility to be borne. Compare, for instance, a service for retarded children to the family, adoption, or child guidance services. Where will you find the degree and duration of such dependency problems, except possibly with severe mental or physical illness? In the outpatient service at the Woods Schools [1] we are always struck by the inevitable question that is asked at the end of a session when we have interpreted the results of our evaluation of the child. "When do you want us to come back?" they ask. Inherent in this powerful question is the hope that maybe next time we will see improvement, as well as the expressed need to have support in carrying the burden.

In our experience, "one-shot" evaluations are of little value. Results are too often denied or distorted by the parents and signal a start on the dreary rounds of looking for someone who will speak the hopeful words they want to hear. A service that carries with it the sincere wish to share the burden of the long-term problem will enable parents to accept a current interpretation of their child's problem. This is not a conscious withholding of information. It is a realization that the true and final expression of a child's handicap and potential cannot be predicted, but must evolve out of the parents' use of our definition of the problem given to them, as well as the climate which they may provide for him. A two- or three-year period, with planned or periodic follow-ups, allows parents time to work on their own feelings, with the specific directions and help

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[1] The Woods Schools are a private residential school for 400 children with mental, social-emotional, physical, and academic handicaps. Children are placed within the school according to chronological age, mental age, social-emotional age, degree and nature of problem. Comprehensive care is given, including special education, diagnosis, psychotherapy, and lifetime care.

given them through the service. The shortcoming of the one-shot evaluation is that it frequently blocks the positive parental feelings from the fullest expression.

CASEWORK FOCUS

Our own philosophy attempts to transcend direct "counseling" of parents. By this I refer to the oft-used precept of counseling: to diagnose the problem and then divulge it to the parents, together with a specific bit of advice such as "He will always need supervision." This is fine as far as it goes, and represents an important medical responsibility to parents and child. A more meaningful and skillful counseling, however, is directed toward helping parents to use this information, but with sympathetic understanding of their need to develop certain natural defenses such as denial or avoidance. One must recognize the traumatic quality and endless ramifications of their problem. These need to be seen and dealt with one by one as they emerge out of the child's daily life. In this way parents can, with a caseworker's support, organize their feelings to give positively to the child, creating a parent-child relationship that supports the child's growth and development as a person, however handicapped he may be.

Should retardation be seen as the same or different from work in other areas in which social work has traditionally been engaged? One may quote Kelman:

> In the course of the last two decades the dimension and implication of problems of mental retardation have begun to be more clearly understood. The problems of the retarded have now come to be viewed as essentially similar to those of any other major chronic illness or disabling condition and some important advances have been made in recent years in the development of methods of rehabilitation, education and socialization. But despite the striking advance in knowledge and technique over the past two decades, a large gap still exists between what we know and how we have been able to help the parents of retarded children and the children themselves.[2]

Casework counseling of parents of retarded children seems to be a relatively recent innovation, and until now emphasis in the literature has been on the establishment of a diagnosis with its interpretation to parents, generally given with a specific recommendation. In our setting we use the residential placement as a structure for a long-term effort to help parents with their feelings, as related to the child and his problem. The preparation for placement, the decision, and actual placement usually represent the healthy impulse of the parent to help his child. Though this act is guilt-producing by virtue of its inherent element of rejection, it also releases the problem, with relief from guilt, in the sense that the parent has done something which will help the child. It has been our experience—and hence philosophy—that the thorough working through of parental feelings toward a retarded child is a lengthy task demanding both persistence and skill.

Our focus is on help with problems developed in having and relating to the retarded child. These are seen as significantly different from the attitudes of the parent before his child is born. The latter represent the rightful concern of the psychiatrist. The former, constituting ego-derivation from the problem itself, are more concretely the concern of the social worker —the area where he can make the greatest contribution as a counselor of parents.

UNIQUE PROBLEMS OF THESE PARENTS

What are some of the specific or unique problems of the parent of a retarded child? Unique, in this sense, means problems that are quantitatively the same as those present in all families but occur with unusual intensity in the families of retarded children. They constitute core problems in

[2] Howard R. Kelman, "Social Work and Mental Retardation: Challenge or Failure?" *Social Work*, Vol. 3, No. 3 (July 1958), p. 40.

virtually every instance where there is a retarded child. They include disruption of normal ego functioning of parents and therefore disruption of normal family life routines; development of excessive and unusually intense feelings of guilt and personal inadequacy; excessive and long-standing dependency burdens that cause emotional draining in parents; friction in connection with siblings because of stigmata and untenable goals which the family has set for itself; distorted perceptions of the child; and finally, distorted projections on the child. Unfortunately, space will not permit discussion of the latter two categories.

The blow of having a retarded child, or learning later that one's own child is retarded, is severe. Whatever the parents' personality organization, the delivery of a severely retarded child is a terrible shock and disappointment. The disruption to normal ego function in parents, and particularly in the mother, is clearly evident and to be expected. In an unusually poignant paper, Ada Kosier has described the impact of the birth of a baby with anomalies on the parent as follows:

> The threat to him of having produced a child severely malformed may be so great that he may not be able to carry even the most urgent of parental responsibilities. He may try to leave his baby in the hospital indefinitely; he may deny the baby's need for special treatment; he may neglect the baby physically or he may devote himself so exclusively to the child that he is cut off from other life experiences.[3]

Most parents go on to organize some kind of defense lest the pain become completely unbearable. With or without skilled help they mobilize themselves to make some kind of plan for their child and themselves.

Probably the largest number of parents feel at the time of the birth of their child that he is normal. It is only later, as his development lags, that he is seen as not normal. Still later, however, in recapitulating, many mothers admit that they suspected rather early that their child was different. Statements such as "He was just different," "He was too still," and "He was like a lump of clay" are common and express the extra burden that mothers carry for their closeness to their child. We have known some mothers who fought the world on behalf of their child, almost because they knew too soon that the child was different. They had a secret that acted as a bond between self and child. The invasion of the outer world and its harsh realities could be climaxed in no other way than a pitched battle in which their struggle to maintain the cherished secret was waged.

In attempting to understand these parents one becomes aware of a number of recurring factors. First of all, it is most often the mother who is most threatened; second, it is the mother who may later develop the self-isolating and martyr-like tendency that often identifies the extreme stereotype concept of a parent of a retarded child; and third, the mother usually acts as though she has been insulted by life—as if she could no longer be fulfilled. Whatever the exact nature of the threat to the mother in having such a child, in extreme cases it seems that nothing anyone can do will remove this feeling of mutilation to the self. One mother we know spoke of the "sobering effect"—that she could never look on life in the same way as before. And countless mothers comment on the bitter frustration and their feelings of lack of fulfillment because so much of their love seems to be for naught. Some of them tend to force their mothering on the child because they refuse to be denied this pressing need of their own. It is paradoxical that in one instance a mother may place her child when he is very young and forever feel a sense of emptiness, while another says, "I know I'm being selfish but I'm keeping him at home until I die. I don't care what happens after

[3] Ada Kosier, "Casework with Parents of Children Born with Severe Brain Defects," *Social Casework*, Vol. 38, No. 4 (April 1957), pp. 183–189.

I'm gone." At the Woods Schools we are more apt to be in a counseling relationship with the former, who feels left out of her child's life. We encourage these mothers to visit and share in their child's care and planning in any way that is practical and psychologically sound. We know of many such mothers who achieve some fulfillment by working for programs for retarded children and by supporting other parents in gaining perspective on their situations. These are important outlets if recognized as giving temporary stop-gap results.

This threat to one's feeling of wholeness that comes from having a retarded child is a difficult thing to work with or even to generalize about. The feelings of guilt and inadequacy are extreme and intense. Much has been written about the parents' feelings of guilt at having borne a retarded child, but little is known about how to relieve these feelings. It is as though this guilt became a part of the parents' character. After a period of time there is no available thread for helpful unraveling. From the caseworker's standpoint one needs to work something through for oneself to develop acceptance of parents who may not be able to see the true nature of their child's handicap and are self-punishing as a result. When a caseworker can do so, parents are less threatened and can come to see him as helpful and supporting.

SHOULD EVERY PARENT ACCEPT THE CHILD'S HANDICAP?

The point of view of the writer, as well as his predecessor [4] at the Woods Schools (and others),[5] is that not every parent can be expected to "accept" the handicap in his child. Perhaps it seems too passive to say that some parents should not accept the degree of handicap because to do so might endanger their mental health. Yet I know of one such case where the child came to be a way for the mother to avoid being grown up and taking on the roles of wife and mother. She and the child are virtual siblings, to the exclusion of the father. The strength of these feelings is evidently great, for many well-intentioned people have been ignored when they have given her "advice." It reminds us of John A. Rose's article on part-time mothering, which points up that each person has a way of solving his own life problem.[6] This, of course, is a psychological application of Cannon's principle of homeostasis.[7]

A caseworker can be of infinite help to parents in this dilemma by being clear as to which parents are motivated for change and can use active help and which must proceed in the darkness, always warding off anyone who seeks to help them change. However, there are many parents who, though severely handicapped by their own guilt, can use the support and warmth of another person. Over a period of time they can come to a greater realization that their role as parent to their handicapped child may always be a partial one, never completely fulfilling, yet with potential for satisfaction, depending on the degree of the child's handicap.

A case in point is a mother who described her own anxiety and terrible disappointment at having her child away from home, but at the same time expressed full realization and acceptance of the fact that he would undoubtedly need to be away all his life. As she spoke she evolved her own plan, which the caseworker supported, that the child should spend part of every summer with the family as long as it was practical to do so. We agreed that this would serve several purposes. It would enable both parents to feel more fulfilled and take away some of the awful

[4] Mary Carswell, "Helping Parents in the Private Residential School Setting," *Proceedings of the 33rd Spring Conference of The Woods Schools* (Langhorne, Pa.: The Woods Schools, 1958), pp. 86–98.

[5] Eve Mayer, "Some Aspects of Casework Help to Retarded Children," *Journal of Social Work Process*, Vol. 7 (1956), pp. 29–49.

[6] John A. Rose, "Child Development and the Part-Time Mother," *Children*, Vol. 6, No. 6 (November-December 1959), pp. 213–218.

[7] W. B. Cannon, *The Wisdom of the Body* (New York: W. W. Norton & Co., 1932).

feeling that they were withdrawing from their child or doing little for him. It would give the whole family a chance to interact, out of which each could develop his own relationship to the child and his problem. Finally, it would give the child a feeling of membership in the family and the support he needed in using the school placement from year to year.

FATHERS

Just as mothers are concerned and responsive, fathers may be equally so. It would seem that, because of the closer biological tie, the mother suffers the more intense feelings. In our own setting we find fathers more removed, less emotionally involved, more objective, and less expressive of their feelings. It is always harder to understand fathers because we do not see as much of them. We have made some interesting observations about fathers who appear extremely guilty. They have been, for the most part, overtly warm people, nearer to the maternal role than usual; they are more apt to turn their hurt into aggression because of their inability to tolerate strong feelings, or to resist subbornly a working through of these feelings.

One such father harbored a deep resentment against his child for almost ten years. His own shame at having the child, and fear of his own strength associated with the child's negative strength, was very great. It was only after he had expressed much of this deep feeling to the caseworker that, in his words, he "became a different person." The child felt the difference and responded almost immediately. Whereas in the past the boy had always detoured around his father, he now began to share many of his thoughts with him, tested and accepted his strength, and began to identify with him as his father and as a man. Later, in describing the change, this father said he could not figure out what had happened—in the past he had not missed his boy while he was away at school, but suddenly he did!

It is a moving experience to share with a father the moment when he allows himself to feel the deep emotion of having been tragically struck by having a severely handicapped son. One father was recently bringing out his wife's question of whether she should continue to visit their boy, a severely defective child who has been a student in the school for a few years. The parents visit faithfully, but the visits have had no apparent meaning to the child. The father was saying that he hoped his wife would want to come in to talk to me too, because as we spoke many questions were raised which needed to be explored. He was particularly concerned about what the other children at home would feel if they stopped visiting. Then, as if it were too much for him, he said he would not want to come just once every five years—the shock of seeing the boy physically changed might be too great. He liked to come for reassurance. He felt better when he came, even if the visits did not mean anything to him or to the boy. When the caseworker suggested that he came because Jimmy was his son, tears welled in his eyes and he could hardly get out the words as he repeated, "Yes, Jimmy's my son; that's why I come to see him." The affirmation, as he acknowledged his son, was in his voice as he spoke.

Fathers also appear to have a particular problem with their retarded child when they have not yet achieved, or are currently working through, their separation from their own fathers. As with mothers at a similar point in development, the ability to carry through in their own role depends a great deal on how liberated they are and feel. It is interesting, for example, to note how often fathers have a problem merely in relating on a level at which the retarded child is comfortable. It seems that the retarded son may create a real puncture in the male ego unless the father is well established as father and husband. This problem is often expressed in aggressive and disapproving action. More subtle and difficult to help is the father who smothers

and denies the boy his own manhood. Adolescence is particularly stormy, but affords some basis for confrontation and identification between father and son.

The excessive and long-standing dependency problem presented by having a retarded child may take different forms for each parent. It is usually the mother who seems caught up in the day-to-day burden and the father who presents the greatest challenge in holding to the present in working through areas of feeling. Parent after parent expresses concern and question about "what will be later." We attempt to support the parent in concentrating on the present, but also to respect the problem of the future because it is very real. The relative helplessness of the handicapped child causes much concern about how much emotional and economic investment can be risked and made available at one time or on a sustained basis. Those who have been engaged in long-term foster care will recognize the similarity here. Again, note the interminable quality of the dependency and how deeply it affects parent reaction to responsibility.

SIBLINGS

Concerning the problems that occur in connection with siblings, we have noted clinically that parents frequently give this as a reason for putting the child into an institution. A Mongoloid child is quite acceptable in the home until his sister starts dating, but then becomes a major focus of concern. In many cases families handle this kind of problem by institutionalizing the child, which then stirs much guilt. On the whole, we believe that parents should take things as they come, little by little, year by year. Some problems, however, can be predicted. Casework done with foresight will help families plan accordingly, so that they do not set their total family goals without realizing their full implications. There is thus less guilt and more meaning to steps taken later.

Most parents have a hard time allowing siblings to have their own relationship with the retarded child who is away at school, and supporting them in it. Often, this is because of parental concern with what will happen after they die. It is especially hard for parents to keep from becoming controlling—frequently an expression of their own ambivalence. That is, they unconsciously put the sibling to work carrying their negative feelings. Inevitably, and contrary to conscious parental expectation, this ends up in estrangement rather than healthy compassion between the children.

It takes a unique form when the child has been placed in an institution at an early age—before five, for example. Because the parent has often not had sufficient connection or bond with the child, the separation takes on an absolute quality and the placed child does not view his parent as a parent but merely as a visitor. A parent in this situation is unable to help the sibling with the relationship because his own is so unsatisfactory and unfinished. This, together with the unnaturalness of visits with an institutionalized child, makes it extremely difficult to sustain without guilt and strain.

There is an interesting contrast between parents' use of residential care for their child and their use of outpatient help. Work with both is equally challenging and deeply satisfying. The family whose child is being cared for in a residential school strives to find a part-time relationship in which they and the child can derive satisfaction from one another. The family whose child is at home presents the sharper need for help because their problems are more immediate. They come to identify their community outpatient service as a source of support and direction in understanding their child and his behavior and helping them to meet his needs.

Work with both groups is rewarding and represents to all engaged a challenge to be met as we develop more resources to deal with the needs of the retarded child and his parents.

BY ERWIN M. LAIBMAN

Group Counseling with Parents in an Agency Serving Adolescents

How does a casework agency serving adolescents, with high volume of work and limited staff, find ways to reach more parents without reducing the time spent with adolescents? This was the problem we tackled at Youth Service of Cleveland, a private, nonsectarian agency focused on the emotional problems of adolescents. The need to work with parents was based on the recognition that in families with adolescents the interaction among family members, always of vital importance in understanding individual behavior, becomes intensified in emotional pitch and complexity. Ackerman states: "The stability of the family and that of its members hinges on a delicate pattern of emotional balance and interchange. The behavior of each member is affected by every other." [1] Added to this is the factor that parents of adolescents are confused about, and are seeking ways to handle, the emerging independence of their formerly manageable children.

Frequently, as Sherman has pointed out,[2] we find parents who can more comfortably expose their self-protective and self-regulatory processes in a group situation than in individual treatment.

With this in mind we decided to experiment with a group counseling approach, and to emphasize strongly the educational aspects of the group experience for the participants. After considerable staff discussion, the following objectives were decided upon:

1. We would seek to develop increased awareness among parents of their own involvement and emotional interest in their adolescents' problems through expression and clarification of their own feelings and attitudes.

2. We would expect them to learn things about themselves through observing how they interact with others in the group situation.

3. We would hope to see them obtain relief of tension through recognition that many problems are common to all families, and that there are ways of modifying such problems that they have not yet tried.

4. We would select for referral to community and private resources those people with personal and family problems, discovered through the group process, that are not within the scope of our agency's functioning.

5. We would observe and record clinical data for diagnostic and research purposes, and attempt to study whether group discussions can help shorten the time span from case intake to successful closing.

6. We would anticipate strengthening of individual determination and ability to improve family relationships through

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[1] Nathan W. Ackerman, *Psychodynamics of Family Life* (New York: Basic Books, 1958), p. 23.

[2] Sanford W. Sherman, "Utilization of Casework Methods and Skills in Group Counseling," *Casework Papers, 1958* (New York: Family Service Association, 1958).

achievement of group unity in connection with common problems.

This paper is a discussion of the results obtained from our first two groups.

SELECTION AND STRUCTURE

In considering who should be in each group, the agency staff weighed the pros and cons of confining the service to parents of adolescents already known to Youth Service or of offering it as a service to the community as a whole. Because of limited time and resources, group membership was restricted to families already known to the agency.

In the final selection of the groups, homogeneity of family patterns was a key factor. It was felt that when a group is set up for six or eight sessions only, quick involvement and active participation are necessary to render the experience most effective. For this reason we chose from those already known to be most oriented to parent education—the middle-income, largely suburban families who are active in PTA's and community organizations. In reference to such families, Eisenberg has stated:

> The middle-class family is characterized by a weakening of parental authority. Parents are perplexed about what to expect of their children. Able to provide for them in a more opulent style than that available in their own youth, they wonder how much to provide. With less of life centering in the home, these children are less responsive to their parents; especially so, since the parents are uncertain as to what they should teach. And, most lamentably of all, these ungrateful young pay more attention to the values implicit in the way their parents live than to the occasional dutifully administered sermon.[3]

Among the forty families initially considered there were three Negro families. The twelve finally selected for the first two groups were white. Ten of the families were Protestant, two Catholic. All were from suburban areas; they had a total of thirty-two children, twenty of whom were adolescents. The following criteria were used in the selection:

1. Parents chosen from cases where the Youth Service client was living at home and where the family situation was relatively stable.
2. Parents chosen who consciously advocated nondelinquent values, were of at least average intelligence, and were oriented to an educational approach.
3. Parents without gross pathology, with some indication, through their background, that they were able to relate in a group.
4. No attempt to establish homogeneity of adolescent problems, but rather an attempt to draw from both sexes and from a variety of problems. Also, if possible, preference given to families with one or more younger siblings.

Case records were submitted by individual caseworkers, read by a committee of our staff members; possible participants were selected, and the caseworkers then contacted the prospective participants. Interpretation to the selected families was that an additional service was being offered which might be valuable to them in improving relationships in their homes. The response was surprisingly favorable, with very few families rejecting the proposal outright as unsuitable or undesirable. Many of those who did not accept the invitation had valid reasons for not being able to participate, such as a prior commitment on the night selected for the group meetings.

The first group consisted of twelve people, the parents of six adolescents being seen at Youth Service. A fee of $15 per family was charged for a total of six sessions of ninety minutes each, held weekly. The second group consisted of eleven parents from six families (one father was un-

[3] Leon Eisenberg, "The Family in the Mid-Twentieth Century," in National Council on Social Welfare, *Social Welfare Forum* (New York: Columbia University Press, 1960), p. 109.

able to attend). This group lasted for eight sessions (one of the recommendations of the parents in the first group) and the fee charge was changed to a sliding scale of $30 to $3. While our aim was to make the groups as nearly self-supporting as possible (sessions were held in the evening after agency hours, with extra pay for leader and recorder), there was provision in the agency budget so that some parents, otherwise eligible but unable to pay, could attend. Attendance was excellent in both groups, averaging about 80 percent for individuals and 90 percent for families.

A flexible organizational plan was followed in both groups. The leader opened with a restatement of the purpose as being to improve family relationships and communication and to increase mutual understanding between parents and the adolescents. After parents introduced themselves and told a little bit about their families, the leader presented a brief description of the structure of the family in our present-day society, contrasting it with the concept many still hold of the traditional family of fifty or one hundred years ago. In subsequent sessions in each group, the leader presented brief remarks on various subjects pertinent to family life in general, or to specific questions raised in the groups. Some of these subjects were the adolescent drive toward maturity, biological growth and psychological factors in the sexual make-up of adolescents, the value system of adolescents, the adolescent need for love and respect as it differs from that of the younger child, and specific problems such as control over hours and dating, discipline, schoolwork, and choice of companions.

In each session, the parents were encouraged to discuss anything they had on their minds, and session plans were modified accordingly.

GROUP INTERACTION

In anticipating the nature of group interaction, it is not enough to select group participants on the basis of social and cultural homogeneity alone. It is also necessary to consider each parent in terms of psychosocial diagnosis, level of ego adaptation, and the unique features of his or her relationship with the adolescent client. In individual cases, parents are seen by the caseworker regularly, occasionally, or not at all, as the current situation warrants. But an essential part of the plan for our parent groups is a relationship with and contact with the adolescent's caseworker. Frequently in the caseworker's office the parents are able to consolidate the new thinking generated in group discussions.

In both groups, almost all the parents adjusted rapidly to the new situation, and after the leader's introductory remarks they were able to participate in discussion comfortably. They seemed to sense almost immediately that they had nothing to fear from each other or the leader, and even in the first session were able to bring up matters that they had probably not discussed with anyone before. Thus, in the first session of the first group, one mother opened the discussion by stating that she was too permissive with their middle child (the Youth Service client) and her husband was too strict. She knew this inconsistency was wrong, but felt that she was driven to her position by her husband's strictness. These remarks provided the group with a topic for lively discussion for half an hour. In the first session of the second group, a mother described for group discussion her two sons, comparing the son being seen at Youth Service with his older brother. Here, the sharp contrast in parental attitude toward the two boys was immediately noted by other parents.

In each of the groups we found that the parents could talk freely about problems of control and discipline, schoolwork, cooperation (or lack of it) in household tasks, and the difficulty of communication between parents and teen-agers. The one area they found difficult to discuss was sex. To facilitate discussion on this topic, a

film was shown—"Who Is Sylvia?"—issued by the Canadian Department of Mental Hygiene. In this film, such problems as sibling rivalry, dating, necking, and communication are dealt with, and it helped the parents to loosen up a bit in the discussion of sex. It was apparent, from what parents said in both groups, that the usual form of communication with the adolescent on the subject of sex was a book or pamphlet handed over rather quickly with the comment that "this will tell you what it's all about." The usual response to this from the teen-agers was that they already knew about it, and this additional source of information was not necessary. The leader cited, at this point in both groups, that from counseling experience we have learned that most of our teen-age clients either have misinformation or no information about sex. Their haste in denying the need for discussion of sex with their parents does not come from a sophisticated accumulation of knowledge.

In general, in both groups, discussion in the sessions centered on a topic introduced by the leader. However, the parents knew they were free to bring up any topic for discussion, and at one session in the first group a mother requested that the group discuss her daughter's school problem. From the seventh grade on, this girl was frequently in trouble with the school authorities, and was suspended several times for truanting, misbehavior, rebelliousness, and so on. As the group discussed this, it developed that both parents, particularly the mother, spent hours with the girl, coaching her, helping with homework, and looking things up for her. The girl, who is bright, seemed to grasp everything at home, but then went to school and failed miserably on tests. The leader pointed out that the girl seemed to be using school performance as a weapon against her parents, and wondered what would happen if the parents would take away her ammunition by withdrawing from direct activity in her work while maintaining their interest in her doing better. Many of the other parents responded sympathetically to the problem and offered a number of suggestions for handling it. The girl's parents left the session with the determination to try a hands-off policy. At the next session, the girl's parents were the last to arrive, and the others immediately asked them, before they could sit down, what had happened during the week. The mother reported that when they had come into the house after last week's session, their daughter was waiting for them with a homework problem. The mother brushed past her, saying she was sorry, but it was up to her daughter to do the work; she was tired and was going to bed. She told the group that her daughter was so surprised she nearly fell off her chair, but got busy and did her homework. In fact, during the week she got four A's and one C+ in her subjects, and was very proud of her accomplishment. The leader pointed out that the girl was now gaining attention through achievement, a far more satisfactory experience than gaining attention through failure.

In all cases, the group experience seemed to have the effect of directing the parents' energies toward seeking a constructive solution of their problems. A good example of this was the development shown by the least stable set of parents in either group. In this family, the mother is a seriously disturbed neurotic with a facial tic, whose hostility and bitterness were expressed openly from the first session. The father is a passive, withdrawn man who at first did not speak at all until encouraged directly by another father. For the first four sessions these parents were unable to direct their attention to anything but their own personal problems, relating to their son as an affliction on them rather than trying to find an empathetic approach to his difficulties. Yet, by the fifth session, when the school problem mentioned above was raised by another parent, this family was able to participate directly and actively in the dis-

cussion, forgetting their own troubles for the moment while trying to help the other family with its troubles.

Constantly in all sessions in both groups, the leader emphasized the positive, ego-building aspects of the points raised by the parents, and if something was raised in a wholly destructive tone, the parents were asked to comment on other ways of handling the problem. Thus, when one father, a problem drinker, brought out that he had urged his 17-year-old son to drink freely "at home" so that he would not think it was something he had to sneak, another father told of what had happened in his home in a similar situation. His son had been given permission to drink beer at home, and one day the father discovered that the son and a friend had finished off a case of beer. The group then picked up on this and concluded that teen-agers need strict controls in this area as well as in others. When one mother mentioned that her 14-year-old daughter had been dating a 19-year-old boy, the hazards in such a situation were discussed by the other mothers, with the first mother finally conceding the points but insisting that if parental objections were raised her daughter would be all the more insistent on seeing this older boy. (It is material like this that the leader refers back to the individual caseworkers for handling in their interviews with parents.)

It was found that when one or more of the parents was silent for any length of time, it was not always left to the leader to get them back into the discussion. Other parents frequently would direct a question to such silent members, usually in a friendly manner that brought a positive response. On the other hand, if a hostile question was directed from one parent to another, it was not encouraged by the group and there was little negative interplay. In the first group, one man was obviously attracted to a jaunty redhead, the youngest of the women present, and, perhaps by accident, he managed to sit next to her in four of the five sessions he attended. However, despite the icy glares his wife threw at him and the redhead, the situation did not deteriorate at any time to the point where it interfered with the flow of discussion. The most negative interaction noted occurred, as might be expected, between marital partners. This ranged from mild objection to what was said by a husband or wife, to an explosive "now just a cotton-pickin' minute!" uttered by one mother whose husband had been constantly belittling her. If these groups had not been specifically oriented to discussion of problems arising from interaction of adolescents and their families, and had not been given a specific limit on the number of sessions, it is easy to see how they could have moved from the level at which they were established into a more intensive program of group therapy. Whether because of the homogeneity of the groups, or because of the absence of gross pathology, or from a combination of these and other factors, the leader did not find it difficult to maintain the original limits of treatment set for the groups.

CONCLUSIONS

After both groups had been completed, the agency staff examined the results of the group sessions. The assessment was made from three angles: a committee was appointed to read the case records of the parents selected for the groups to predict how they might participate and to estimate what they might get out of it; the leader and recorder were to report on how the parents actually participated; and finally, the individual caseworkers were to report on what comments the parents made to them afterward.

The committee reporting on how they expected the parents to participate came remarkably close to the way in which the leader and recorder saw the parents as actually participating. Typical comments of the committee (who had no parents in the group from their own case loads, and had not read the recording of the group

process) were: "This man expected to be more inactive in the group discussion than his wife." "This mother would participate on an intellectual level; the father would attempt to be the center of attention." "The father would be very verbal, the mother would feel less free to discuss in the group." "This woman expected to participate on intellectual level, father in soft-spoken manner." There was virtually no comment made by the committee which was contradictory to what the leader and recorder observed in the group sessions themselves. This suggests that from an examination of adequately recorded family history and interaction it is possible to achieve a high rate of expectancy as to degree and quality of participation in goal-limited group counseling.

In nearly every case, the parents' reports back to individual caseworkers expressed positive feelings about their participation in the groups. Some of the comments were: "We can see how we acted differently with (the Youth Service client) than we did with his brother." "Learned to be more relaxed." "Can now see daughter as an individual." "Have the feeling we can better handle problems that may arise." "The trip to and from the sessions together gave us an opportunity to discuss things about our son that we didn't have before." "It was a relief to see other parents with the same kind of problems."

As the second group neared its last session it became evident to the leader that the parents were seeking some specific recommendations for handling situations at home. With this in mind, the parents were presented with two lists of points to remember regarding the attitude of parents toward adolescents, and the amount of responsibility shown by adolescents. Regarding attitude, the parents were advised to (1) treat adolescents with the regard owed to any human being—show respect for their thoughts, feelings, and wishes; (2) avoid prying into their secrets or private life; (3) take as little exception as possible to their behavior, be diplomatic in attempts to change it; (4) avoid any teasing or ridicule. As for responsibility, it was pointed out that those adolescents who show the most responsibility (1) feel that they have a stake in family life; (2) know that their efforts will be noticed and appreciated; (3) know that other family members are carrying their share of the load; (4) can be given jobs and carry them to completion without being under excessively close supervision.

The problems that brought together the parents in our groups centered on parental control, school performance, molding the adolescents to adult standards of socialization, and concern over the choice of friends and sexual interests. They were coming consciously for professional guidance and advice in these matters. The group experience provided a socializing relationship with other families not expressed or provided for in other social systems to which they belong. It would seem that the parents who benefit most from this type of group experience are those whose readiness for communication is sufficiently near the surface to be brought into the open in one or two sessions.

While the experience derived from just two groups is not enough to validate any hypotheses, an examination of the original objectives in light of experience can be made, and certain tentative assumptions drawn.

1. Did parents develop increased awareness of their own involvement? This cannot be evaluated concretely, but a study of movement in the families who were in the first group reveals (eighteen months later) successful termination in four out of six, with significant progress achieved. For example, a seriously delinquent boy has maintained steady employment with one firm, received several promotions in this period, and has changed his outlook to such an extent that he now contemplates a career with this firm, having adopted his

family's values. Another boy, also seriously delinquent before the first parents' group got under way, has finished high school, married his neighborhood sweetheart, and is working steadily, with plans to get further special industrial training. One girl (the school problem cited above) has become sufficiently motivated to graduate from high school, has become engaged to a young man acceptable to her parents, and is confident regarding her future. Increased awareness by the parents of their own involvement, with resultant modification of attitudes, played an important part in these gains.

2. Learning about themselves through the group process was something the parents were able to express much more directly. Almost all of them, in summing up their experience in the groups, commented on how much they learned in this manner. Coming together for a specific purpose, having a leader attuned to the process, they benefited from a unique educational interchange.

3. The parents were also able to express directly their feelings of relief from tension through universalizing their specific problems. This was due particularly to the social and cultural homogeneity, which they recognized at the first session. (One mother remarked to the leader, "You sure picked a select group.")

4. The careful selection obtained in these two groups was responsible, perhaps, for the absence of situations that had to be referred to community or private resources. However, this still remains a possible function of the group.

5. The abundance of clinical data, of course, is apparent. Our first two parents' groups were not specifically geared to any one research goal, and, even if they were, could not provide any conclusive evidence from so small a sample. There has been staff discussion of tape-recording sessions for study, and a number of ideas are being considered about how to structure future groups for research goals.

6. The determination and ability to improve family relationships as a result of the group experience can only be evaluated at a later date by seeing where the respective families are. Just as we went back to the records to see what happened to the parents in the first group, so we will examine the records of the second group, the third, and so forth. The indication is that the group experience has a significant, beneficial effect for most families. Only time and study can prove it.

The parents who participated in the first two groups told us, directly and by their actions, that they want to learn, they are hungry for knowledge, and they are willing to be shown ways to modify their attitudes and behavior constructively in order to enhance family interaction. At the same time they have taught us that there is validity in using group counseling to ameliorate family relationships and improve communication between adolescents and their parents.

BY LUTHER E. WOODWARD

Changing Roles of Psychiatric Social Workers in Outpatient Clinics

SOCIAL WORK, EVER since its early development at the turn of the twentieth century, more than any other profession has specialized in the complexity and the significance of interpersonal relationships. In such a profession, role changes are inevitable, especially in time periods when social changes are many and rapid. Role changes that have been occurring recently, and are likely to continue to increase for some time, seem to be related to four major facts of life in the clinical field: (1) changes in clients or patients and their respective needs; (2) the increasing maturity of social workers as members of the multidiscipline team; (3) the broadening of social perspectives in mental health; and (4) community demands for functional efficiency. Motivations for the adoption of new roles, and for shifting the balance of activity in established roles, may stem from any one or any combination of these four features of the profession within the framework of the social scene.

ADAPTING ROLES TO PATIENT NEEDS

Almost every clinic in the country testifies to the greatly increased numbers of people who are knocking at the doors of clinics for help with an increasing variety of mental, emotional, and social problems. Waiting lists are almost universal, and in many instances excessively long. In New York State alone, 62,000 patients were admitted last year, and the number is still growing; and by every known method of classification they constitute great variety. By age, they range from under 5 to over 65. They include every diagnostic category. They come from almost every possible source of referral. In severity of problem, they range from 3 percent who have no mental deviation to another 3 percent who have chronic brain syndrome, and 11 percent with psychotic reaction.

Thirty to thirty-five years ago outpatient clinics were basically of two kinds, namely, community child guidance clinics and adult aftercare clinics for exhospitalized mental patients. Patients in the latter were almost entirely postpsychotic adults, and children coming to child guidance clinics were comprised of primary behavior disorders, childhood neuroses, or troublesome antisocial or other acting out behavior. Today, in New York State alone we have 106 all-purpose clinics, 70 child guidance clinics, 38 that serve adults only, 7 that serve retarded and mentally deficient children, 6 for the treatment of alcoholic patients, and 1 for aftercare treatment of drug-addicted persons under 21 years of age.

Some of the recent role changes in clinics relate to changes in both inpatient and outpatient services of mental hospitals—

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role changes that are occasioned largely by the changing philosophy of patient care with particular reference to open-door policies and earlier release to communities. This means that not only clinics associated with the hospitals but community clinics also are receiving increasing numbers of these patients who are returning to the community before being fully recovered and in greatly increased numbers. It is no longer true, as it was even a few years ago, that the mental hospitals and community clinics have entirely distinct and separate patient groups. There is now considerable flow from hospital to clinic, and from clinic to hospital. A statistical analysis of this flow on a sample basis in New York State as of February 16, 1960, indicated that 15 percent of all patients whose service was terminated in outpatient clinics in the fiscal year 1959 had a previous or subsequent admission to a state or licensed mental hospital, or school for defectives. Eight percent had had an admission to such an inpatient facility prior to their clinic admission, 6 percent a subsequent admission, and 1 percent had a combination of both. The estimated percentage of clinic patients who subsequently entered inpatient facilities within two years is about 16 percent for those 55 years of age and over, as compared with 7 percent for persons under 55 years of age.

To give effective help to the exhospitalized patient calls for a radical change of role from what had become almost traditional in many outpatient clinics, namely, an uncovering, more or less free association type of therapy. The postpsychotic patient by and large requires acceptance of himself as he is, with supportive and somewhat authoritative counsel or advice regarding management of everyday situations and relationships, together with the worker's interpretation of the patient's limitations and needs to the essential persons with whom he is associated. The needed frequency of contact may vary widely from time to time. Sometimes service is required only on an intermittent basis, but in almost all instances consists of a combination of environmental planning together with ego-building and social adaptation, often within short limits appropriate to the patient's limited adaptive capacity. Suitable living arrangements, appropriate job, family acceptance and the rebuilding of a few social relations, rather than depth therapy are the more common goals.

Roles of psychiatric social workers in clinics are again changing in response to the needs of the increasing numbers of seriously disturbed children who come to clinics, or who are being cared for in residential treatment centers and day care programs in local communities. Reliance must be placed on slow, patient development of a meaningful relationship notwithstanding deep regressions or violently impulsive behavior. On the one hand, one must be wholly available and fully giving, and on the other hand structure the social stage so that the child will find needed opportunity for control and protection. Again, the social worker must play a differently adapted role with brain-damaged children, who comprise 9 percent of clinic patients under 5 years of age and 5½ percent of those between the ages of 5 and 9. Still other adaptations must be made in working with the 15 percent of children under 10 years of age in outpatient clinics who suffer from mental deficiency. This involves working with additional medical specialists, diminishing usually a great deal of guilt on the part of the parents around the child's damage or deficiency, creating a more relaxed and comfortable emotional climate in the home, and helping child and parents to establish and achieve realistic limited goals. Such roles are radically different from those involved in working with child or adult patients of good intelligence and physical vigor and whose problem is basically emotional in nature.

Still other variations in role with patients and collaterals stem from the trend

away from child guidance clinics per se to all-purpose clinics, and a growing number of adult clinics. This inevitably means a broadening of the spectrum of services, if services are to be planned in accordance with patient needs. For example, in New York State approximately 30 percent of all patients under 20 years of age are classified as transient situational personality disturbances, but above 20 the percentage in this group drops to about 4 percent. Obversely, in the age group under 20, psychoneurotic reactions and psychotic reactions comprise a low percent (4–8) and personality disorder only slightly higher, but the percentage comprising these groups jumps rapidly above age 20, comprising 17 percent of psychoneurotic patients, 19 percent of psychotic reactions, and about 34 percent of personality disorders. Without describing more specifically the diverse roles which social workers must play in serving this great variety of types of patients, suffice it to say that a considerable repertoire of insights and skills is required to serve young children and aged persons, persons with no mental deviation and those with brain damage, those with transient situational personality disturbances, more fixed personality disorders, and a variety of neurotic and psychotic reactions. One of the primary facts of life in the clinical field is that there is no one professional role or methodological procedure that can be used effectively with all types of patients or clients. In every instance, the role and procedure must be adapted to the nature of the patient's problem, to his remaining strengths, and to the worker's areas of competence.

FOUR CHANGING ROLES

In diagnosis and treatment. Through the years, psychiatric social work has been officially defined as "social work that is carried on in responsible working relationship to psychiatry." This definition has proved to be masterful both in what it says and in what it leaves unsaid. It was a workable definition in the early days when psychiatrists and other physicians spoke of social work as an "ancillary profession," when the chief responsibility of the social worker was to assemble a miscellaneous array of social data at the request of the doctor, when the doctor reserved to himself the right to extract from the social history what fitted in with his own interests and diagnostic impressions of the patient, and the social worker was not privileged to engage in diagnostic or prognostic thinking and document his conclusions from the social data compiled. Conceivably, that may still happen. The writer observed this in various hospital settings not more than a decade ago, but today things are different. One rarely hears reference to "ancillary profession," or to the social worker as the "psychiatrist's handmaiden." On the rare occasions when such terms are still used by young psychiatric initiates or by oldsters in years who are new to outpatient clinic work, the upstanding psychiatric social worker is apt to "pin back his ears," in a pleasant and responsible way of course, and proceed to trace the etiology of the problem in the patient's and family's history and current relationships and go on to indicate what very probably can and cannot be accomplished in view of this history and the nature of the present problem. In the course of making evaluative reviews of many clinics for licensure or for state reimbursement, it is a delight to see psychiatric social workers present the most salient facts in a clear-cut concise way that reflects sound diagnostic thinking and a careful weighing of all the social and personality factors which enter into determining the method of approach in casework, or other type of therapy to be undertaken, and prognosticating the probable outcome. In an increasing number of clinics, it is policy for the social worker to spell out in summary form his or her best diagnostic formulation, and to contribute equally with the

other members of the team in treatment planning.

In intake. A second more extended role relating to professional maturity involves the social worker's part in intake. While this has always been a major function of the social worker, twenty years ago this was carried on in a rather leisurely and global sort of inquiry of the patient, his family, and various other social resources in the community, all of which ended in a decision to let the patient in or to keep him out in accordance with certain broad, predetermined policies. The social worker was chiefly the gatekeeper or watchdog of the clinic, in some instances with more interest in the "outkeep" than in the intake. While in my opinion many clinics are still too restrictive in their admissions policies, especially favoring the particular type of neurotic or personality disorder which the staff prefer to study and treat, clinics are exhibiting a more socially responsible attitude toward the community.

All-purpose clinics which attempt to serve all segments of the community, and which find many patients seeking service who have suffered an acute onset of illness or are in a social crisis that cannot await leisurely intake procedures, are setting up what is known as "rapid intake service" or "emergency service." Here the psychiatric social worker takes on a role that is different from the traditional intake function. The patient or one or more collaterals are seen almost immediately. The initial inquiry is sharply focused on the onset and nature of the immediate acute problem and its meaning to patient and various members of the family; and the potential strengths of the patient and family and other potential resources in the community are weighed for a quick though tentative psychosocial diagnosis and for immediate planning purposes. Other members of the team move in with equal speed, so that all members of the team have participated in the study within a two- or three-day span. A plan for the patient and/or family is made, and both patient and responsible family members are involved immediately in their own next steps. Much depends on the social worker's assessment of both the degree of pathology and the inherent strengths in the patient and his family members. If care outside the home and clinic is recommended, the social worker quickly organizes the necessary community resources to implement the plan, or if emergency treatment at the clinic is agreed upon, the social worker carries on as one of the most active members of the team, sometimes directly with the patient, sometimes as interpreter to and supporter of members of the family.

In some clinics, the social worker speeds up the intake process and promotes a meaningful kind of self-selection on the part of prospective patients by assembling groups of patients numbering 15 to 30 or more, as soon as some such number have made application or have been referred to the clinic. In some instances, this is managed in a single session of one to two hours; in other clinics a series of meetings is planned. This provides opportunity for the prospective patient group to learn something more of the nature of emotional and relationship problems and to attain some understanding of what will be required of them in study and treatment at the clinic. For varied and quite personal reasons, some automatically screen themselves out and withdraw their application. Others become better motivated for study and treatment, and are prepared to move in with more rapid cooperation as soon as service is offered or become fortified for a waiting period if this becomes necessary.

Goal-limited social treatment. In the third place, as was described in some detail elsewhere, psychiatric social workers are increasingly carrying on appropriate realistic goal-limited social treatment.[1]

Whether the service is brief or extended,

[1] Luther E. Woodward, "Increasing Social Work Effectiveness in Meeting Mental Health Needs," *Social Work*, Vol. 5, No. 3 (July 1960), pp. 65–66.

both the philosophy and method depart largely from the considerably overused psychoanalytic prototype and use basic casework skills in promoting healthier relationships with other persons who have significance. Quoting Charlotte Towle:

> Today, our social work self is being revived; in fact, it constitutes the "new" in social casework. In rediscovering family-centered casework, we no longer see the psychodynamics of family life largely as a means to understanding and coping with the individual's pathology. These insights are now considered essential for helping an individual with close reference to those in relationship to him for his benefit and for the welfare of the family group.
>
> Very important, also, is our rediscovery of the validity of differential relationship oriented to the client's need and capacity rather than to our own need to enact a prescribed therapeutic role. We have been re-finding our own style in our casework focus and treatment emphasis, rather than emulating the psychoanalyst's style. Although we are still guided by psychoanalytic understanding, we are challenged anew by the knowledge and skill entailed in the competent performance of our comprehensive function as social workers. There is no ego-deflating simplicity in the return of the social component into social casework practice.[2]

Administration. A fourth role which social workers in their greater maturity are carrying is an increasing participation in clinic administration. In one populous county in New York State, the administrative director in 11 of the 16 clinics is the supervising psychiatric social worker (in three clinics located in community hospitals the administrative director is the psychiatric director, and in two community clinics the chief psychologist is the administrator). Several facts conspire to promote the use of psychiatric social workers in administrative capacities. In the first place, increasing numbers of psychiatric directors of clinics are engaged in private practice part time, and they prefer to concentrate on definitive psychiatric study and treatment and on the professional supervision necessary to carry the medical responsibility for the clinic's work. More fundamentally, psychiatric social workers with extensive experience in hospitals, clinics, and other types of community agency bring to the administrative task a wealth of knowledge about community resources and an unusual degree of skill in establishing and maintaining effective working relationships. A number of the most smoothly running and most effectively operating clinics are found among those with social work administrators.

A fuller account of these and various other roles is described elsewhere.[3]

ROLES AND BROADENED SOCIAL PERSPECTIVE

A psychiatric clinic to be effective today has to be more than a clinic. Even in its basic team collaboration in dealing with the confusion, anxiety, depression, and hostility which grow out of disturbed personal relationships or manifest themselves in disturbed behavior, it is necessary to give attention to a great diversity of community circumstances which can adduce disturbed behavior. It is often just as important for all immediate purposes to see that some other service is provided, such as to ensure a stable home by making it possible for a deserted mother to stay with her children, or help a depressed, unemployed father find a job, or see that a school child is placed in a grade with a teacher and peer group best suited to his potentialities, as it is to try clinically to resolve emotional conflicts and relieve inner tensions which

[2] Charlotte Towle, "Marion E. Kenworthy: A Social Worker's Reflection," *Social Service Review*, Vol. 30, No. 4 (December 1956), pp. 447–448.

[3] Luther E. Woodward, ed., *Psychiatric Social Workers in Mental Health* (New York: National Association of Social Workers, 1960).

in part may stem from the past. Mental health, in other words, is a many-sided entity, and both its achievement and its maintenance constitute a many-sided job.

It has been more and more recognized in recent years that the base of a community mental health program must be much broader than the hospital and clinic alone, and that the community's core of mental health personnel must include many additional specialists (beyond the psychiatrist, psychologist, and social worker) who have helpful face-to-face relationships with people. Physicians in general practice, nurses, clergymen, schoolteachers, school administrators, court workers, and others, once they possess the necessary understanding, have high potentials for relieving mental and emotional distress and promoting positive mental health among their patients, parishioners, or pupils.

In recognition of this need to broaden the base of informed and effective mental health work, psychiatric social workers participate in community educational and consultant services in various ways. Sometimes they do this unilaterally and carry on in-service staff education with community agencies, and at other times together with either the psychiatrist or psychologist or both. The psychiatrist tends still to carry major responsibility in strictly medical settings, such as a general hospital, or in educational efforts with general practitioners in the community. In schools, courts, welfare departments, health departments, more often than not the social worker carries major responsibility, but this is sometimes shared with both the other clinical disciplines. For effective educational and consultant work, a high degree of maturity is required. One must be undergirded by a full measure of confidence in one's own professional competence, and at the same time be prepared to do a great deal of learning about the other discipline's basic frame of reference and characteristic ways of looking at human behavior. No one can achieve maximum effectiveness in such educational and consultative work in the first few months of such effort.

It is not claimed that a majority of psychiatric social workers are engaging increasingly in educational and consultative work. Many workers have resistance to getting out of the more familiar clinical mold of a one-to-one relationship, and find it difficult to relate effectively to groups of other professionals. It is clear, however, that each year there is at least a slight increase in the percentage of social workers who are comfortably, and hopefully effectively, engaging in this type of activity. In a majority of our psychiatric clinics in New York State, the social workers are giving a higher percentage of time to educational and consultative functions than are the other disciplines. There are some notable exceptions in the case of some psychiatrists who are much interested in community psychiatry, and in broadening the base of understanding in all branches of medicine.

Another role related to the broadening perspective in mental health is that of participation in research, which is being conducted by clinics and related agencies. Movement into this role has been rather slow, but is picking up steam. Admittedly, most psychiatric social workers have not been adequately trained in research methodology, but some types of research definitely call for the social worker's knowledge of community resources and his skills in promoting collaborative relationships. Those who are engaging in research activities usually find themselves teamed up with sociologists, anthropologists, or social psychologists, from all of whom they can learn considerably. Yet they find their basic social work insights and skills valuable tools in carrying a research frame of reference, that is, within a suitable and clear-cut research design and the consistent and systematic use of specific methods and tools, so that unknown variables cannot creep in. Within the writer's personal knowledge, psychiatric social workers are carrying on

research along with representatives of other disciplines in alcoholic clinics, psychopharmacological clinics, clinics for mentally deficient and retarded children, clinics devoted to family study and treatment, and clinics carrying on basic epidemiological studies.

INCREASING EFFICIENCY

In New York State, a recent time study of a sampling of outpatient clinics revealed that both supervision and recording are being used excessively and wastefully. All staff members in the sample clinics recorded in code the activity engaged in during every 15-minute period in four consecutive working weeks. Thirty-nine percent of social worker time was used in these direct services;[4] 48 percent of psychologist time; and 51 percent of psychiatrist time. The range of social work time used in direct service in the five clinics studied was 31 percent, 34 percent, 45 percent, 48 percent, and 49 percent. No clinic quite made the halfway mark. The really big blocks of time used in other than direct services were those devoted to dictation, recordkeeping, mail, and so forth (on the average 30 percent) and supervisory and other than interdisciplinary conferences (on the average 17 percent), or a total of 47 percent for these two types of activity. In one clinic which engages in a great deal of professional training, the combined percentage of time in conferences and in recording was 59 percent, and in one regular community clinic that does not engage in training 50 percent of time was so used.

The total hourly cost for direct service time in the combined clinics was $10.79 for social work alone, and $15.36 for total professional time. The range in social work time was from $9.72 to $12.95, and the range of hourly costs for direct services by all professional staffs was from $14.11 to $16.68.

As more tax funds are allocated to clinic operations, either in the maintenance of public services or in the utilization of local or state tax funds through contracts between voluntary auspice clinics and official mental health boards, the public is demanding increasingly to know what it gets for its money. A most likely way of reducing the per hour cost of direct services is to increase the relative proportion of time devoted to direct services. On two counts, psychiatric social workers are in a position to increase the clinic's efficiency and to reduce the unit costs. In many clinics, the number of social workers exceeds that of either psychiatrists or psychologists, and as was indicated in the figures just cited, social workers are using a lower percentage of time for direct services than are the other disciplines.

Fortunately, a small but gradually increasing percentage of clinics is working toward this end. Several clinics have dispensed with process recording entirely and are presenting in summary form only salient facts and significant movement. This means the reduction of records by 50 to 80 percent, and correspondingly increases the usefulness of the records. Social workers and members of the other disciplines, too, indicate that although such changes are difficult, they can be effected in the course of a few months by consistent effort.

Likewise, in a growing number of clinics social work supervisory time is being appropriately reduced. In terms of workers with several years of experience and with proven skill, the frequency of regular supervisory sessions is being greatly reduced, if not replaced, by available consultative time on request of the worker.

[4] The following five types of activity are considered as direct services: (1) interviewing patients or collaterals, (2) group sessions with patient, (3) significant telephone interviews, (4) consultations with other professional persons outside the clinic or with persons not counted as patients, and (5) community service sessions, *i.e.*, sessions with community groups for educational, consultative, or community planning purposes. "Direct services" does include consultation and educational services as well as contacts with patients and collaterals.

To be sure, direct services can never occupy anything like 100 percent of total clock time. There must, for instance, be time for interdisciplinary collaboration, for without that we do not have the essential feature of a psychiatric clinic. There must continue to be some discreet recording and issuance of reports to other agencies or professional persons. There must be some administrative conferences for development and revision of basic policies and administrative procedures. It is possible for clinics that are concentrating on clinical study and treatment and group community services to approximate a 75 percent goal of direct service time. For social workers this could mean almost a doubling of the present 39 percent. Accentuation of the several newer roles cited in this paper should add to the proportion of time devoted to direct services.

BY MARIE McNABOLA

Research and Mental Health in the School

NATIONAL CONCERN WITH mental illness and disabling emotional disturbances in the general population has resulted in expanded support, through state and federal programs, in the areas of research, training, and services. Many of these activities have been centered on children and families, with particular attention to the school-age child and the school experience. The child during the prescribed educable period becomes the focus of community as well as parental concern and responsibility for his education and development. In itself this is an expression of democratic ideology, reflecting at once the sense of mutual responsibility for the common welfare and an almost magical belief in the ability of education to foster optimum development. To meet in part the pressure for the realization of this ideal the schools have had to develop a complex of services of their own, by design or under pressure of crisis, some of which include utilization of practitioners from other fields.

Public health shares with the schools the responsibility for healthy development of the child. One of the main goals in public health has always been control and prevention of health hazards, and this concept is now defined to include mental illness. The complexity of mental illness, involving as it does biological, psychological, social, and cultural factors, necessitated the development of a multidirectional attack on this particularly obstinate and involved health problem. The magnitude of the school population and the urgency of working with the nation's most precious resource—its children—have made the study of mental health in schools a prime responsibility. This paper will review the programs developed by the National Institute of Mental Health to meet that responsibility.

Definitive knowledge of the cause of mental illness, with its devastating results in families and communities, is as yet lacking. Even though knowledge of causation is minimal, we are aware that there is an intricate interrelationship between the biological and psychosocial aspects of human behavior and illness. Schools have been pressed, despite the limited knowledge, to initiate programs for the promotion of mental health. In line with this, the definitions of "mental health in schools" and "mental health" in general are still unsatisfactory and remain largely operational definitions. The result of this pressure has been a certain amount of confusion and disgruntlement. The comment by Sir Oliver Lodge that the last thing in the world that a deep sea fish could expect to discover would be salt water, wryly and all too aptly describes the situation in which research and service programs on mental health in schools have been developed. Programs have had to include an analysis of the interplay between schools and other social institutions as well as internal analysis of special problems. In order to formulate a coherent approach, the National Institute of Mental Health has developed a multifaceted program of research for the study of the etiology of mental illness; training programs to meet the manpower

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needs for skilled investigators and professional personnel; and community services to aid in the improvement of the quality of service and the design of programs.

INSTITUTE STUDIES

The research program of the institute is composed of a grants program to individual investigators and studies conducted by the institute's own staff. Within the institute the program is divided into the basic and clinical sciences, where the endeavor is to have a constant interdisciplinary research effort. The four basic laboratories are child psychiatry, adult psychiatry, psychology, and socioenvironmental studies. One of the best-known projects of child psychiatry has been an extensive investigation of a group of hyperactive, emotionally disturbed boys. These boys had been dismissed as incorrigible from a series of schools and were known to the police for robbery, vandalism, arson, and many other problems. They were patients at the institute for a number of years, during which time a team of specialists, including teachers, concentrated on finding a usable program to control their pathology.

The laboratory of adult psychiatry has now under way a cohort study of first-year college students, whom they first saw as seniors in high school, to find out what the most stressful factors seem to be in the college milieu and what varying kinds of family background contribute to the ability or inability to tolerate these stresses successfully. Disturbed adolescents breaking down under first-year college pressures are admitted to the institute for continued study and help. The research hypotheses of this study are being tested cross-culturally in Puerto Rico.

The laboratory of psychology—which includes experimental, social, child, and clinical psychologists—operates, as do the other laboratories, under a broadly conceived mandate which allows study of the functioning of normal as well as disturbed children and families. Studies in this laboratory focus on the processes of psychological change during infancy, childhood, maturity, and old age. One such study is an intensive investigation of the socialization of the newborn and infants; another is a longitudinal study of child development.

The socioenvironmental laboratory—including anthropologists, social psychologists, and sociologists—pioneered in the study of the effect of mental illness and hospitalization on the family. A study centered on families in which the father was hospitalized examined such questions as how the family decided the father was ill, what the paths to the hospital were, what the mother did to hold the family together, and what mothers told their children was wrong with the father. Another study of particular interest has to do with the ways in which middle- and working-class families raise their children, with special reference to the handling of authority and affection.

In the institute's community research station, known as the Mental Health Study Center, community mental health procedures are developed and tested. This center has been conducting a longitudinal study of reading disability as an index of potential emotional disruption and maladjustment in children and is tracing the psychological and sociological factors associated with maladjustment. The high frequency and ubiquity of learning disruptions are of obvious concern to educators. For them and for public health workers, such a study may eventually result in a screening device which would assist in better case-finding and preventive actions.

RESEARCH GRANTS

The multidirectional attack on the problem of mental illness is most apparent in the research program. Under this program, grants are made to provide financial aid to qualified investigators in universi-

ties and laboratories throughout the nation. Studies have been undertaken in genetics, biochemistry, neurophysiology, and psychology, as well as on social and cultural factors. Some of these studies have sought to test "classroom atmosphere," while others have undertaken evaluations of mental health principles and concepts currently employed in schools. In addition, there are intensive studies of the biological and social needs of children with special needs, such as the mentally retarded, the maladjusted, the physically handicapped, and the gifted. A few studies are related to the values and procedures of the educational institution itself, such as teacher selection and performance.

Psychopharmacological investigations have expanded considerably during the past several years. Of particular concern are studies of the use of drugs on children. Greater understanding of drugs may contribute, in time, to the provision of more adequate medical care for children and assist in studies concerning the effect of drugs on learning and personality development. Many other studies not classified in the area of school mental health—for example, the psychological aspects of development, learning, and perception—have an indirect contribution to school mental health, as do the increasing number of sociological and cultural studies of environment and its effect on learning ability.

One of the greatest benefits deriving from the institute's grant program is support of studies requiring long-term follow-up. One particularly interesting example is a study in a large urban area in which an attempt is being made to determine the impact of the school experience on the personality development of children. The focus of the study is not only on the performance of the children in school, but also on parent-child relationships, the organization and administration of the school, the relationship between home and school, and the role of the teacher in school and community. Hopefully, this study may bring us further knowledge of the dynamics of school-home-community, from which more effective services may be developed.

COMMUNITY SERVICES

The community services program provides grants-in-aid to states for community-based mental health activities; Mental Health Project Grants for demonstration and evaluation studies; and direct consultative services through its regional and national offices. Mental Health Project Grants is a relatively new program, designed to stimulate study of the methods and techniques for treatment and rehabilitation of the mentally ill. The extent of mental affliction in the general population requires that study and evaluation be given to the level of services currently available, and that intensive study be devoted to special areas of need and treatment. In addition, studies are needed which will aid us in making more effective use of the limited professional manpower and the extension of resources through such activities as mental health consultation. Many projects related to school mental health are being supported through this program. Study subjects include early detection and management of emotional illness, the effectiveness of added school services in relation to maladaptive behavior, and mental health education programs for mothers of school children. Some studies directly related to program-planning to meet special needs concern: rehabilitation of emotionally disturbed blind children, a language program for mentally retarded children, and a pilot day nursery for schizophrenic children. Other studies focus on interagency relationships such as those of clinics and schools.

The grants-in-aid program has assisted states to develop a number of demonstration or experimental services related to their particular local needs. In one state, the departments of education and health have joined in a project centered in its

rural counties. A team composed of a clinical psychologist and a mental health nurse, making use of existing county facilities, is studying the screening and local management of school children with minor emotional problems. Another such project is an evaluation study to assess the effectiveness of school social work and school psychology programs. These various projects point up the importance of looking closely at existing programs and resources and making use of what we already know. Some of the early results of these studies indicate that many persons are unaware of existing services which, if used, could partially meet current mental health needs. How to reach individuals during periods of stress is the focus of several programs which have established emergency psychiatric services on a twenty-four-hour call basis, and similar programs are experimenting with services which send mental health teams to the home. In regions of the country where distance and the small number of professional personnel limit accessibility to help, experiments are being made with short-term forms of treatment.

TRAINING

The range and depth of activities noted in research and community services also characterize the programs in training. Grants are available for both basic professional preparation and special training of personnel in relationship to mental health. The institute's training grant program is the largest of such programs in the National Institutes of Health and one of the largest administered by the federal government. Grants are available for the training of psychiatrists, social workers, psychologists, nurses, public health personnel, social scientists, and physical scientists particularly concerned with studies of human behavior. Special grants are also made on a pilot basis to strengthen, develop, and evaluate mental health content in training for related groups such as education, theology, and the law. These three groups have a vital relationship to the community and to individuals suffering emotional stress and mental illness. The projects are evaluating the mental health content that should be included in the educational processes of each group, the purposes and timing of such material, and follow-up studies as to the effectiveness of the training in later activities.

Training grants for school social work and school psychology were initiated several years ago, with school social work selected as the first area for expanded support. This decision was based on the belief that strengthening social services in the schools offered the most hopeful potential for future preventive procedures and design of new forms of service. Grants in school social work, as is true of all grants in the training program, provide funds for teaching personnel and trainee stipends for students. They are designed to assist universities and other training centers to improve the quality of their program and to expand the training facilities.

At the time grants in school social work were initiated it was thought that the program might be slow in developing, because of the small number of schools of social work offering this sequence and the lack of adequate field work facilities. Within the three-year period of grant support the imagination and enthusiasm of practitioners in school social work have assisted universities in materially expanding their training potential. Student interest in this area has shown a marked increase, and during the past year 117 trainee stipends were awarded to students in school social work. Such a beginning is encouraging, but in view of the needs not particularly a matter for optimism. The contribution of social work to mental health needs in schools continues to rest with the preparation of skilled investigators and with the creative practitioner capable of making use of studies and experiments to evaluate his own

practice and design programs for more effective service.

The multiplicity of activities described in this paper might well cause the practitioner to ask, with T. S. Eliot, "Where is the knowledge we have lost in information?" The research process is a slow aggregation of new knowledge and of rediscovery. Real progress is being made in the development of methodology for evaluation, though this process, too, is slow and arduous. The increased number of social work investigations is heartening and a critically needed dimension of interdisciplinary studies of mental illness. Such studies may eventually guide the practitioner to use his experience with greater precision and aid him in making accessible the information gained through his daily knowledge of the impact of stress.

The responsibilities asked of the schools by the public are enormous. The desire for progress is made more urgent by the pressure on schools to deal with the consequences of social change—delinquency, illegitimacy, narcotics, and other morbid features of modern urbanization. For the practitioner, as for the scientist, the study of mental illness and health requires a continual assimilation and adaptation of the accomplishments and findings of any relevant endeavor. A child and family in need must be helped. It is hoped that professional knowledge and history will aid us in helping them to live with—and beyond—the lacks in knowledge that so seriously affect their lives.

BY JACINTA MURIEL DE GARCÍA

Yambele: An Experience in Community Organization in a Public Health Setting

HEALTH IS A vital asset for the individual and for society, and the protection and maintenance of health constitutes one of the basic aims of social welfare. In North America, social work—and particularly medical social work—has long been recognized as contributing to the attainment of health goals. Yet its contribution has been confined mostly to the rendering of social casework services to individual patients undergoing medical care in a hospital or clinic.

This limitation of medical social work was acknowledged by participants in the Chairmen's Conference called by the Medical Social Work Section of the National Association of Social Workers in 1958. They held that: "The needs of the total population for medical social work services are greater than can ever be fulfilled solely by the direct practice of social casework. There is need to find other ways and means of bringing its knowledge and skill to bear upon human need." [1]

Contrary to the North American tradition initiated by Dr. Richard C. Cabot at Massachusetts General Hospital, in Puerto Rico medical social services were originally established in the State Department of Health in 1924, when—upon recommendation of the Children's Bureau—Nellie Foster was appointed supervisor of social services for the Maternal and Infant Hygiene Program.[2] The very fact of its location in a public health program provided a broad base for medical social work practice in the island. For, as Dr. Winslow stated in his comprehensive and inspiring definition,

> Public health is the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community effort for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity.[3]

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[1] "Report of the Special Conference on Community Health," New York City, September 1958, prepared by Kurt Reichert for the Medical Social Work Section (New York: National Association of Social Workers, 1958), p. 1.

[2] *Annual Report of the Commissioner of Health of Puerto Rico for the Fiscal Year 1923–24* (San Juan, P. R.: Government Printing Office, 1924), pp. 129–141.

[3] C. E. A. Winslow, "The Untilled Field of Public Health," *Modern Medicine*, March 1920. Quoted by J. J. Hanlon in *Principles of Public Health Administration* (2d ed.; St. Louis, Mo.: C. V. Mosby Company, 1955), p. 20.

Thus, the medical social worker in a public health setting must realize that in order to be truly effective service must be directed not only to the individual, but also to the groups and to the community to which the patient belongs.

The story of Yambele is an example of how a field work student was helped to identify the contribution of the medical social worker in the area of community organization, and how he, as member of a multidisciplinary team, could help secure a better adjustment between the health needs and the resources of the community.

ORGANIZING THE COMMUNITY

Yambele is a small semirural community, a ward of Río Piedras, the university city of Puerto Rico. It is located on the outskirts of the city, very close to one of the bigger shopping centers, and consists of thirteen acres of land divided in small lots and sublet to individual tenants. Its name, Yambele, is actually the Spanish pronunciation given to "Jean Belle," the name of the original French owner of the estate.

In 1954, when the community organization project began, there were 71 families living in Yambele, comprising a total population of 450 persons. The majority of the heads of households were construction workers, and the average income per family was $160 a month. The average educational level of the population was a fourth-grade elementary school preparation.[4]

The great majority of the inhabitants of the community had been living there for a period of five years. They were former residents of urban slums, displaced by a slum clearance program. Instead of living in one of the available public housing projects they preferred to move their houses—literally—from the condemned slum areas to a lot in Yambele because, as they said, these houses were their very own and they could later leave them to their children. Since Yambele did not conform to the zoning and building regulations established by the planning board of Puerto Rico the community was not served with the public utilities of light, water and sewerage.

Organization of the community started with a request for help by a patient of the Río Piedras Public Health Unit of the State Department of Health to a social work student of the School of Social Work of the University of Puerto Rico who had been assigned to this agency for his field work. Patient and student had come in contact through a casework relationship concerned with helping the patient in the solution of social problems complicating his illness.

One day in March 1954 he came to the student's office to express his satisfaction at the help received; at the same time to inquire whether the student could extend his services to the community in general.

The problem as presented by the patient was lack of running water and electricity, as a result of which the neighbors, he said, had to bathe in a contaminated stream and drink impure water out of wells. Many, like himself, had bilharziasis (Manson's schistosomiasis), and the children were suffering from "chronic diarrhea." The patient also told of individual efforts made by several members of the community to find solutions to these problems. One had written the governor asking for help, another had addressed the mayoress of the city government, while a third had presented the situation to the planning board. Since these efforts had been to no avail, the patient was sure that if somebody with influence (which he was sure the student had) interested himself in the problems of the community the solutions could be found.

[4] Unpublished census, Río Piedras Public Health Unit, Puerto Rico Department of Health (May 1954).

The student conferred with his supervisor and it was deemed desirable to find out whether the community was conscious of its health needs and whether its members were willing to join their efforts for meeting these needs. Accordingly the student asked the patient if he might call a meeting of the neighbors who had distinguished themselves by their interest in solving the problems.

Ten persons, recognized leaders of the community, attended this first meeting, and they offered to call a mass meeting for the neighbors to discuss their problems in more detail. The student, in turn, planned to bring with him other persons from the health unit who might be of some help.

The student then had individual conferences with the members of the public health team. The medical director approved of the project and stimulated the staff to participate. The field work supervisor attached to the school of social work and a social worker from the staff of the health unit offered to continue helping the community, once the student finished his term at the field work center. The health educator, in turn, offered to participate actively in stimulating the participation of the community in the solution of its public health problems. Both the nurse and the sanitary inspector assigned to the zone were already familiar with the community. The sanitary inspector was engaged in a campaign for the building of latrines, while the nurse had visited the homes of her patients.

When these professionals had been reached through individual interviews, the student called a group conference of the members of the team. Thus an advisory committee was formed. A tentative date was agreed upon for the meeting at Yambele and it was decided that at this meeting the team would try to find out the scope of the health problems of the community and the possibilities for co-ordinated action.

IDENTIFYING THE COMMUNITY'S PROBLEMS

A mass meeting was held in Yambele on the evening of May 14, 1954, with seventy-five adults present. The number was considered an adequate representation of the community. Some heads of households had excused themselves because they had to work at the time of the meeting.

This served to get a consensus on what the members of the community considered to be their problems, while the consulting staff stressed the importance of pooling their efforts toward solving these problems. In addition to electricity and running water, the neighbors were conscious of the need for adequate recreation facilities, and were worried because so many in the community looked "anemic" (probably suffering from uncinariasis). They also felt that if some classes on child care were given right there in the community, families would improve their health habits, as well as their attitudes toward the children. By the end of the meeting the enthusiasm shown by community members had been conveyed to the consulting staff, and the health educator planned to bring a film showing what another community had done to help itself in the solution of a problem.

The following week the picture *Una Voz en la Montaña* (A Voice in the Mountain), produced by the Division of Community Education of the State Department of Education, was shown and the student social worker and the health educator led the discussion of the film. It was felt that the community had grasped the message and that the neighbors were willing to join efforts in solution of their recognized needs.

After another mass meeting in which the preliminary orientation and the definition of health problems was continued, the neighbors elected a "Committee of Leaders for the Welfare of Yambele," which consisted of a president, a secretary, a treas-

urer, and two representatives of the five most populated sections of the community. Contrary to the student's expectations, his client, who had originally involved him in this project, was not elected president. The community preferred a more influential leader: the storekeeper, who was also the owner of several lots. The patient was chosen as representative of his sector. Another point of interest is that five women were appointed to share the responsibilities of leadership together with eight men.

The committee of leaders met regularly on Tuesday evenings to continue discussion of their problems and to explore possibilities for their solution. While the advisory staff was always accessible for consultation, they also joined the residents of Yambele once every fortnight to continue the educational program, participate in the ongoing evaluation of the process, or confer with the leaders and assist in further planning.

The meetings were held in a building which was the property of the president—formerly a dance hall but now bearing a sign that reads: COMMITTEE FOR THE WELFARE OF YAMBELE. Furnishing this place was one of the first ventures in working together of the inhabitants of Yambele. They gave small contributions for buying the materials, while carpenters volunteered their labor for making large benches to accommodate the people.

CO-ORDINATING THEIR RESOURCES

The community gave priority to the need for water and electricity and appointed a representative committee to visit the planning board to explore the possibility of extending the public water and electricity facilities to Yambele, even though the community had been illegally established. At the request of the community the student social worker was included in this delegation. During the interview the officers of the planning board made it clear that as long as Yambele continued its growth as a suburban slum it would never receive the public utilities demanded. The residents then held a meeting to discuss the information from the planning board, and the professional team explained what the residents could do in order to have Yambele declared a stationary or arrested slum. All the neighbors promised to watch so that no other clandestine dwellings were built, and they offered to better their own houses to conform to sanitary standards. While the professional team helped to interpret policies and regulations, the neighbors pooled their resources for the building of latrines and the remodeling—in some instances the complete rebuilding—of their homes. After a period of six months the public water and electricity facilities were granted.

The health problems of the community were tackled in various ways. Films depicting common diseases such as ascariasis, gastroenteritis, and uncinariasis were shown. The medical social workers commented on their social implications. Preventive measures were discussed mainly by the health educator and the sanitary inspector. The nurse stimulated the examination of stools, and treatment was given by the public health physicians to persons suffering from parasitogenic diseases. By the end of this campaign the consulting team shared the satisfaction of the community at the fact that all the houses had sanitary latrines, the children were not walking barefoot, and the municipal government had agreed to extend its garbage-collection service to Yambele.

Another objective in this process of community organization was to investigate the incidence of schistosomiasis in Yambele and obtain treatment for infected persons. Health educators, nurses, doctors, sanitary inspectors, and medical social workers participated in the educational campaign and in mobilizing the necessary resources for the treatment of positive cases. Later, a follow-up study was considered necessary,

and the social work students doing their field work at the health unit developed a questionnaire and interviewed all patients. The findings of this survey served to intensify the educational program and stimulate a closer co-ordination between the institutions concerned with the problem of schistosoma—mainly the health units and the municipal hospitals.

When the people of Yambele had been working together for about a year, the members of the new committee of leaders selected by the community demanded formal training as to the duties and responsibilities appropriate to each one of them. This request was viewed by the consulting team as evidence of the growing maturity of the community. The health educator and the field work supervisor agreed to organize a workshop for the training of leaders. Formal participation was limited to the appointed leaders, but other persons were accepted as visitors. The workshop covered subjects such as human relations, problem-solving, mass meetings, and working in committees. The field work supervisor was helped by the students in presenting the material on human relations and group dynamics. Other members of the professional team, as well as representatives from other agencies, served as resources in carrying out the workshop which was attended with great enthusiasm on the part of the community. Following this training the neighbors decided on three working units to facilitate the active participation of a greater number of persons in the planning and execution of their program: a committee for the design of the by-laws and the program and financial committees.

Besides the achievements already mentioned Yambele now has a first-aid dispensary maintained by the group of seventeen persons from the community who completed the first-aid course given by the Civilian Defense Organization; a library, a club for adolescents, and other improvements which they developed with a minimum of help from the advisory team.

By the end of the year 1956 it was evident that the inhabitants of Yambele had learned to work together in the identification of their needs and to co-ordinate their own resources with those of the established social welfare agencies. It was also evident that having filled their most important lacks, the people did not consider it necessary to attend the meetings with the regularity they had shown before. The community was striving for independence.

A similar process was going on in another group much smaller than Yambele, but moving parallel to the progress observed in the community. Since the beginning of the project in 1954 the group of professionals who served as consultants had met regularly to discuss the development of the community and to determine their own participation in the process. By so doing they had learned to respect and to like each other in a measure they had not been able to achieve before. Besides, they had frequent community case conferences with representatives of other social welfare agencies and they were asked to interpret Yambele to students of various disciplines and to trainees from the programs of international co-operation. In short, they shared many rewarding experiences and as a result they too had become an organized community, a real team.

But by 1956 the consulting committee had suffered significant changes in its composition. Because of personnel turnover only two of the original members of the team remained: the sanitary inspector and the field work supervisor. It is only fair to admit that, not having lived through the experience of Yambele, the new members did not share the enthusiasm of the original team, and the stage of development reached by the community in the solution of its health needs was no longer a pressing challenge to them.

Both the local and the professional leaders considered it advisable to sponsor a formal evaluative study on the desirability of continuing the intensive work in the

process of community organization in Yambele. This was done by means of a survey. The professor of research at the school of social work helped in the development of the questionnaire and in the interpretation of the results, while some members of the advisory team and the students of social work then practicing at the Health Unit served as interviewers. As a result of this study it was decided to end the period of intensive work in the community of Yambele during the month of December in 1956.

A NEW PROBLEM

The Third Pan-American Conference of Social Work was held in Puerto Rico during the week of October 21–26, 1957. Some of the participants expressed their interest in visiting Yambele and the field work supervisor sent word to the community. It was a pleasant surprise to see that, not only the appointed leaders, but also many residents of the community, were waiting for the visit.

The neighbors wanted advice on a new problem. Since Yambele is so conveniently located on the outskirts of Río Piedras, many middle-class proprietors coveted the district. In fact, Yambele was being surrounded by new housing developments. The people faced the dilemma of moving out of the district, or improving their houses. The neighbors had already decided on the latter alternative, and were willing to co-ordinate their efforts in the solution of the problem. That evening they were advised about possible resources, and right there they appointed different committees to initiate their exploration.

On the way back from Yambele the visitors commented on the spontaneity and maturity evidenced in the deliberations of the community. They could not believe that the residents of Yambele had only an average fourth-grade education. After a short period of exploration of the resources, which the community conducted without further professional help, Yambele decided to organize a housing co-operative. The Administration for the Development of Co-operatives has been helping them during the last three years. Plans are under way at this writing for the official incorporation of the Yambele Housing Co-operative during the month of October 1960.[5]

CONCLUDING OBSERVATIONS

Yambele is an illustration of the many and rewarding possibilities of community organization for community health planning, and the important role medical social workers may play in the process. The student medical social workers who were exposed to the experiences of Yambele, either as active participants or as observers in the various stages of the process, certainly had a significant and unique opportunity to develop desirable attitudes for working with the individual in his group and intergroup relationships, the opportunity to enrich their knowledge of the concepts and principles inherent in social work, and to practice professional methodology.

The students participated in the deliberate efforts of a community to solve the problem of its health needs. They helped in identifying the felt needs of the people and in setting priorities; in the exploration of both the human and the institutional resources; in the formulation and implementation of a comprehensive plan of action for meeting these needs; and in the progressive evaluation of the activities and the whole program of community organization.

Through their own actual participation in the process, as well as by identifying with the image of the field work supervisor who was also performing a profes-

[5] Interviews with Fanny Quintero, specialist in co-operatives, Co-operative Housing Division, Puerto Rico Administration for the Development of Co-operatives, June 5, 1959, and September 8, 1960.

sional role in the community, the students developed an understanding of the different functions performed by medical social workers engaged in community action. Thus, they realized the important contribution of medical social workers as diagnosticians of the medical-social problems of a community and learned to interpret to the other members of the team, and to the inhabitants of the community, the relationship between social and health factors. As social planners, they helped the community find solutions to their problems, came to understand better the contributions of other disciplines to the health needs of social welfare, and became acquainted with a number of agencies and institutions. They also learned to interpret policies and procedures in simple, nontechnical language. In the performance of their professional role medical social workers, students as well as practitioners, became more effective observers and participants of group dynamics and of the forces influencing the intergroup relationships and had many opportunities for applying their knowledge of individual and group interviewing, research techniques, educational methods, and evaluative insights. The dramatic results obtained in the solution of the community health needs could never have been achieved solely through the casework process.

Thus, the story of Yambele shows how the community organization process opens new avenues for training social work students assigned to a medical setting, and illustrates also the rich opportunities this approach offers for enlarging the scope of actual medical social work practice. The sacrifices that the process requires are surpassed by the unlimited satisfaction derived by helping so many people attain their health goals. Medical social work finds in the process of community organization a significant answer to the problem of finding "other ways and means of bringing its knowledge and skill to bear upon human needs."

BY MARY K. KENDREW, NATHAN NACKMAN, AND EVELYN HOLSEY

Some Dynamics of Committee Interaction

THE SOCIAL WORK profession has recently become increasingly willing to re-evaluate the conventional supervisory conference and has suggested various patterns for the supervisor-supervisee relationship. Possibly the time has also arrived to look at other staff relationships. The focus here will be particularly on relationships operating in that agency device, the staff committee, which is frequently composed of caseworkers with a case supervisor or other superior as chairman. This is a tool employed in social agencies for a variety of purposes: to study recording methods, make recommendations for improved intake procedures, revise mimeographed forms, and so forth.

This paper proposes to examine some of the dynamics operating in such committees and their influence upon the committee's work. The content is based on discussions taking place between members of a committee set up to formulate a staff development program. At the Baltimore Regional Office of the Veterans Administration such a committee is chosen annually. The chairmanship has alternated each year between the supervisors of the two social service groups, and two additional members chosen by rotation, one from the medical and one from the psychiatric group. Structurally, this would seem to provide for the fostering of new program ideas, yet the staff obviously felt a lack of stimulation even though the program content included such diverse elements as case presentations, discussion of administrative problems, summarization and discussion of material from professional journals, and addresses by guest speakers. Each successive committee seemed to have an individual quality and considerable originality, yet these did not find as much expression as one might expect. An attempt was made to look at the interaction taking place within the committee itself, and resulted in the formulations presented here.

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TIME ELEMENT

One point that emerged as discussions progressed was that the amount of time available for committee meetings might serve as a negative or positive dynamic. More was accomplished in meetings when members met with partially formulated ideas. "Prefabricated" ideas, although economical of time, tended to be taken over whole —apparently because other members of the committee, being relatively unprepared, were at a disadvantage.

A committee member who had not been present during the gestation period of an idea might express only a vague reservation, or none at all, about a proposal that did not appeal to him. Being unable to formulate his reservations in specific terms, he tended to go passively along with it. At best his presence was hardly more effective than absence might have been; at worst, there was a subtle resistance that retarded the work of the committee.

During a discussion on the importance of ample time as an ingredient in committee deliberation one member drew an

analogy between the unfolding of ideas and rising yeast, saying that both need a warm atmosphere and time in which to expand. When time was at a premium, so that members were aware of being pressured, programs were evolved which committee members themselves recognized as being second-rate and falling short of their best efforts.

INFLUENCE OF THE SUPERVISOR

The presence of the supervisor, because of her particular role in the agency, tended to exert bias. Other members, sensitive to it, found this somewhat restricting. On occasion, they recognized the supervisor's competence as a valuable corrective to their lack of experience, particularly to make sure that programs should meet the standards the agency had set itself in respect to student training, in which they personally took some pride. At the same time they felt that more creative spontaneity would have resulted were the supervisor not a member of the committee.

There was considerable discussion as to whether a supervisor (or any other superior) is able to divest himself of his role and serve in the same capacity as other members. It was agreed that the ability of supervisors to do this would vary, depending considerably upon individual need to retain supervisory functions in the committee setting. It was also believed that, regardless of the degree to which supervisors were able to discard their role, the freedom felt by committee members would be conditioned by their power to free themselves of hampering feelings in respect to authority. It was unanimously believed that the influences of this factor, stemming from two diametrically opposed orientations, are so inherent that they can in no way be truly avoided. The literature on group interaction bears out this view.[1]

[1] As noted in the sessions on group interaction conducted annually at Bethel, Maine, by the National Training Laboratories of the National Education Association (summer 1956).

In illustration of the above, a committee member formulated the problem in these terms:

> Midway in the year, the two caseworkers on the committee were interested in planning a series of staff meetings to discuss an integral part of the agency's casework program. This project had been discussed and its use anticipated. However, when it was discussed in detail in committee, the chairman appeared only mildly receptive to the idea. Thus, what was previously an apparently acceptable idea seemed about to be discarded. The two members' immediate concern was, "Can a caseworker challenge a supervisor's position?" Both felt that they could not. The consequence was the generation of concealed hostility, a general lack of interest, and a submission to authority that made it difficult to proceed.

COMMITTEE STRUCTURE AND PROGRAM IDEAS

Program ideas emerging after committee deliberation occasionally reflected "power" pressures, revealing that at times the chairman's authority was dominant while at other times the influence of the other two members prevailed. There was sufficient awareness of this influence to permit the caseworkers later to verbalize their resistance to a suggestion made by the chairman that excerpts from James Norman Hall's experiences as a novice social worker be used to launch the student year.[2]

> The two caseworkers accepted with considerable reservation what seemed to be largely a ready-made decision, agreeing that the excerpts provided an amusing account of the frustrations and anxieties that beset the beginning worker. However, the appropriateness of the material was questioned, since it did not seem to be particularly provocative or informative as related to social work. In spite of differences in the matter, its use was

[2] James Norman Hall, *My Island Home* (Boston: Atlantic Monthly Press, 1952).

agreed upon. The uniting force seemed to be trust in the chairman's judgment.

In turn, the chairman's reaction when the caseworker members pressed for the showing of the film *The Family of Man*[3] (from the photographic exhibit of that name) was as follows:

> Although the caseworkers believed that the emotions depicted in *The Family of Man* represented a fine range of the whole substance upon which casework is based, the chairman saw no way of dealing with the element of passivity inherent in the viewing of films. She questioned how fleeting views of disconnected emotion could be used for sustained discussion. She likewise believed that possible damage to the film might result in a financial obligation for which there was no provision in the budget.

In discussing this episode the committee members came to feel that possibly they had uncovered what caused many staff programs to lack stimulus. Perhaps the chairmen were inclined to dismiss ideas that posed problems for which there were no ready solutions. In other words, were stimulating proposals being shelved in favor of conventional programs because the latter required less resourcefulness in developing them?

The other members of the committee were so persistent in this particular episode that the chairmen eventually discovered a financial resource elsewhere in the agency for handling the cost of possible damage to the film, which could be drawn upon by social service. It was decided to secure the film for preview. During the preview, however, what may have been lack of skill in the operator caused a sizable tear in the film. Film damage had now become a reality. This produced unexpected counterreaction in the committee. Although it posed a question as to whether the frequency of future casualties might make the use of films impractical, the chairman was now inclined to favor their use. Being aware of potential dynamics that could stifle creativity, she felt increased responsibility for seeing that this was kept at a minimum. The other two members, however, now beset with anxiety, were inclined to abandon films.

Anxiety abated upon the recruitment of a more experienced operator, and a variety of films were ultimately utilized. The preview of *The Family of Man* enabled the committee to address itself more specifically to its content, and the committee was better able to tackle the problem of how discussion might be stimulated. Although ultimate discussion of the film was somewhat elementary, generic casework principles were brought out in new and fresh perspective.

COMMITTEE STRUCTURE AND AUTHORITY

The members of the committee considered the importance of various patterns of committee composition. One might consist of practitioners all on the same professional level. Another might consist of a group selected primarily for their varied experience. Still another might comprise heads of disciplines in a multidiscipline setting, and so on. In view of committee dynamics already described, it seemed desirable for a member of the committee to be selected as chairman by his peers, rather than appointed or elevated to chairmanship through deference. Thus a member of "officialdom," unless unanimously chosen for chairmanship, would serve by virtue of ability to contribute unique experience rather than of position held. It was appreciated, however, that it would be almost impossible to rule out the factor of prestige in selecting a chairman. This led to appreciation of the fact that committee composition as such is not of prime importance —of equal significance is the ability of each member to feel sufficiently secure within himself to be able to communicate freely.

[3] Edward Steichen, *The Family of Man* (New York: Naco Magazine Corporation for the Museum of Modern Art, 1955).

This will be true regardless of the degree of distortion of authority projected by the chairman, but for individuals who have a basic problem with authority, it will be particularly difficult.

The potential for conflict between committee members and authority remains, of course, essentially irreducible. This is because, regardless of composition, unless executive responsibility is delegated to the committee the approval for decisions will be lodged outside it. Authority is therefore merely once removed. This is characteristic of most agency committees on which caseworkers serve. The experiences of this particular program committee brought out how important it is that the committee's relationship to approving authority be made clear at the time a committee is appointed. To discover inadvertently that the function of such committees is fundamentally advisory rather than autonomous can be quite disappointing to inexperienced members who may rather naïvely suppose that they have been delegated quasi-executive powers.

Although this particular committee realized that the successful elimination of one authority figure in the person of the supervisor would not remove the problem of coping with the final authority figure, the group was nevertheless inclined to feel that a committee composed of members of the same professional level would have advantages. The committee believed, for instance, that it would feel more comfortable in expressing subjective feelings, that there would be a less inhibited flow of program ideas, and that there would be more unanimity in regard to proposals.

OPPORTUNITY FOR GROWTH

In many agencies the ceiling for growth above the casework level is low. Executive and administrative positions, and that of case supervisor, do not frequently become vacant. The most that many caseworkers can anticipate as regards advancement within the agency is the opportunity to supervise an occasional student. Possibilities for variety of experience and the development of other than casework skill are limited. An agency could, however, substantially broaden opportunity through service on committees, if these committees were so designed as to give the casework members the greatest possible responsibility. For instance, feelings in regard to authority come into more healthy perspective when committee members themselves (rather than the supervisor) are responsible for soliciting the participation of various staff members for a particular panel, case presentation, or the like. The discomfort that some members feel in this role provides a new dimension to their concept of authority. Likewise the necessity for reconciling differences of opinion in a committee composed entirely of one's peers can provide insight for appreciating that authority figures are not necessarily the tyrants imagined. (A hint of how salubrious this can be appeared in this particular committee and was borne out later when experiment was made with an all-peer pattern.)

Permission to let a committee learn by its errors may be one of the most difficult prerogatives for an approving authority to grant. It is recognized that permission to utilize questionable casework techniques can provide a very meaningful learning experience for a caseworker, and such planned use of techniques requires principally that the effect upon the client be carefully calculated. Although a corresponding experimentation in program-planning is not obviously fraught with direct hazards to a client, the flexibility necessary to permit it seems more rare. Is this because less thinking has been done along these lines? Or because it is felt as a reflection on one's status as a professional person if the staff development program is not of the highest possible caliber? This problem came into clearest focus when the two casework members of the committee wanted to invite, as a guest speaker, a person from a related field who

was entirely unknown to the chairman. Doubt as to suitability of content and question as to the caseworkers' ability adequately to evaluate content were the troubling factors. Although ways of dealing "safely" with these factors were finally found, the learning potentials in the original proposal were undoubtedly high and probably not as effectively realized in the alternative.

It may be, also, that committee members learn more effectively from the uncomplimentary comments of a critical audience than from a superior's solicitous guidance in respect to anticipated problems. Excessive supervision can produce an apparent compliance which carries little conviction.

An experienced planner tends to evaluate a variety of factors in facilitating audience response. Among them are:

1. Whether the issues are sufficiently live to engage interest.

2. Whether the material has been prepared in terms simple enough to permit the audience to take hold.

3. If prepared material has been issued in advance, whether a means has been devised for leading into it.

4. Whether unclear terms have been eliminated which might lead to irrelevant discussion.

5. What devices have been set up by which discussion can be kept in focus, movement stimulated, and coverage obtained.

Since full appreciation of the significance of such factors can come only from working directly with them, it becomes important not to shield committee members from their impact. As criticism continues to be leveled at social workers for their lack of leadership in public affairs, it seems logical that attempts should be made to stimulate leadership qualities at every opportunity among the rank and file. A step in this direction is to remove as many restrictions as possible, and permit every feasible bit of leeway at the casework level.

REACTION OF STAFF TO PROGRAM

It may be of interest to note that, although the particular committee under discussion produced a strikingly imaginative program (in spite of the interaction described), two opposite kinds of affect were apparent among the staff. The positive side was exemplified by a remark made by a staff member who said, "I get so interested, I keep wondering what the next meeting will be like." This feeling had contagious elements. When the four students at the agency were invited to present some topic interesting to them—as an assignment in addition to their usual case presentation, which had been all the agency usually required—they seemed eager to make a contribution. The readiness with which they were able to decide on topics, the appropriateness of those selected, and the caliber of the presentations were noteworthy.

On the other hand, negative feelings expressed by other staff members were to the effect that the committee's standard was a high one and might be difficult for successive committees to emulate. There were also indications that the novelty was somewhat threatening, and continuation in a routine in which the content of meetings could be more largely anticipated would have been more welcome. Although expressing need for greater stimulus, and clearly implying that ruts are to be avoided, these workers seemed rather tempted by the comfortable qualities of ruts!

In working together it was realized that a committee can be as alive and stimulating as the individuals participating. The unbounded enthusiasm and freshness of the neophyte social worker in the field, and the wisdom and experience of administrators, supervisors, and senior social workers, provide an extraordinary milieu for growth and the interchange of ideas. If members of a committee can find common ground for deliberation without deference to individual prestige, and can keep from vying for authority, a basis is provided for truly creative interaction.

BY VICTORIA M. OLDS

Sit-Ins: Social Action To End Segregation

THE SIT-IN MOVEMENT began on February 1, 1960, in Greensboro, North Carolina when four college students sat down at a segregated lunch counter expecting to be served and refused to leave when service was denied. This peaceful though aggressive movement spread quickly over the South with a tremendous impact in the drive against discriminatory practices. It was a spontaneous though well-organized activity which demanded sufficient self-discipline from young people to enable them to accept without retaliation taunts, insults, and physical abuse from pro-segregationists. The sit-in group would remain at the lunch counter for hours, thus preventing others from being served. Their refusal to leave resulted in arrests on charges of trespass.

These nonviolent demonstrations were reminiscent of the quiet courage of Rev. Martin Luther King during the Montgomery, Alabama, bus boycott, and also of the powerful passive resistance protests of Mahatma Gandhi. The initial reactions of surprise and uncertainty quickly gave way to offers of support from all directions. In March 1960 the *Washington Post* reported that Governor Collins of Florida felt it was wrong for stores to do business with Negroes in one part of the store and refuse to serve them at the lunch counters. Earlier, on February 15, 1960, the *New York Times* stated that the sit-in movement reflected growing dissatisfaction with the slow pace of desegregation in the schools and other public places. Also reflected was a shift in leadership to the younger, more militant Negroes.

Support came in the form of sympathy picket lines before the chain stores in New York City, as well as similar sit-ins in other cities of the South. Offers of legal help came from organizations such as the NAACP, CORE (Congress of Racial Equality), the National Civil Liberties Clearing House, and others. Students at Yale, Brown, Skidmore, and the University of Connecticut staged rallies in support of the sit-ins. Those at Harvard, Radcliffe, and Massachusetts Institute of Technology obtained 8,000 signatures on a petition.

At one point, on March 26, 1960, there were reported to be sit-ins going on in nine scattered areas from Jackson, Mississippi to Little Rock, Arkansas and from Savannah, Georgia to Lorain, Ohio.[1] The reaction of the southern white community was expressed as follows by the *Richmond* (Virginia) *News-Leader:* "Here were the colored students, in coats, white shirts, ties, and one of them was reading Goethe and one was taking notes from a biology text. And here, on the sidewalk outside, was a gang of white boys come to heckle, a ragtail rabble, slack-jawed, black-jacketed, grinning fit to kill. . . ." Hill and Miller consider the sit-ins as part of a social revolution that will bring about drastic changes in a relatively short time. They anticipate new problems on the heels of desegregation, since majority and minority group members will have to learn to adjust to new roles and new relationships.[2]

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[1] *Pittsburgh Courier,* March 26, 1960.

[2] Mozell C. Hill and Alexander F. Miller, "The Problems of Progress," *Anti-Defamation League Bulletin,* Vol. 17, No. 3 (March 1960), pp. 1–2.

SOME IMMEDIATE CONSEQUENCES

Since the onset of the sit-ins, tangible results are evident. Throughout the eastern part of the country, the climate in favor of desegregation has become more generally prevalent. The admiration for the dignity and purposeful determination of the demonstrators has heightened the enthusiasm of individuals and groups who want to help. Lunch counters have been opened to everyone without prejudice as a direct result of the demonstrations. In Arlington, Virginia, where sit-ins were under way in June 1960, a few weeks later five chain stores had opened their lunch counters. These same stores had lunch counters in the District of Columbia, where desegregation is required by statute.

A dramatic boost came in May 1960 from the action of the dean of the divinity school of Vanderbilt University, who, together with nine members of his faculty, resigned in protest against the refusal of the university to readmit as a student a Negro minister who had been expelled from the divinity school in March 1960 because he had been a leader in a sit-in demonstration. On August 11, 1960, Attorney General William P. Rogers announced that as a result of a meeting he held with a group of chain store executives, they had agreed to desegregate lunch counters in their outlets in sixty-nine southern communities. He also reported that as an indirect result of the sit-ins, desegregation had occurred in 70 percent of the sixty-nine communities without prior sit-ins. Rogers emphasized with the store executives the fact that the United States suffers loss of prestige as a world leader as a result of acts of racial discrimination.[3]

This development reflects the influence of a favorable climate of opinion and social pressure. It also illustrates the effectiveness of informal action on an official level and the catalytic and integrating role of the authoritative figure—in this case Attorney General Rogers, but in other cases it could be the professional worker in community organization. The sit-in demonstration proved to be a potent economic lever, because stores reported a drop in income. However, after lunch counters were desegregated, for the most part they reported a normal return of former customers, and in many instances an increase in business.

A similar move toward desegregation was announced on August 16 by Bus Terminal Restaurants, Inc., which operates restaurants in Maryland, Virginia, Tennessee, North Carolina, and Florida. This voluntary act requires no legal step, and will lead to the dropping of charges of trespass against some fifty-five persons in Virginia alone.[4] Here we see that a fortunate combination of factors has made for heartening progress in racial equality. Some of these factors include the international situation, which is making greater demands on the United States to prove its sincerity in wanting to befriend the colonial dark peoples of the world; [5] the national industrial scene, with the pressure for a mobile free labor force; the rising middle class in the Negro group, with a corresponding economic leverage; and the constantly improving intergroup relationships in many communities. The sit-ins provided the initiative and momentum to bring desegregation issues sharply into focus and force a solution.

A newspaper columnist (Roscoe Drummond, in the *Washington Post* for August 15, 1960) comments that three factors must be operating to ensure progress toward equal treatment of all citizens:

1. Negro leaders and citizens must continue to work firmly and persistently for equality.

2. Interracial community organizations must be actively involved to promote better race relations.

[3] *Washington Post.*

[4] *Ibid.*

[5] Gunnar Myrdal, *An American Dilemma* (New York: Harper & Brothers, 1944), pp. 1016–1021.

3. The power and initiative of the federal (or local) government must be in the picture and used judiciously.

Michael Walzer writes that there is developing a "new Negro" who combines militancy and religious zeal in a mass movement with nonviolence, to make the South a better place for Negroes to live. He points out that the students involved tend to come from lower-class backgrounds and have not been hampered by middle-class distaste for direct, militant action and for publicity on racial matters.[6]

A DEMONSTRATION IN A RECREATIONAL FACILITY

The success of the sit-ins at the lunch counters in northern Virginia led to an effort to desegregate an amusement park in nearby Maryland. The interesting development in this undertaking was that it included an active community group as well as the Negro and white students. The Glen Echo Amusement Park, located in Montgomery County, Maryland, is the only such park in the District of Columbia metropolitan area and has always followed a discriminatory policy regarding admissions. It also has a swimming pool and a dance hall. While the District of Columbia government operates public integrated swimming pools, Montgomery County has no public pools. Instead, as in many suburban communities, local neighborhoods have built private pools limited to residents only. Consequently, when faced with making plans for swimming, the recreation department of Montgomery County arranged to use the Glen Echo Pool as the closest public pool for white children, and to send the Negro children in to the nearest District of Columbia public pool. This separation was set up in spite of the fact that the recreation program is an integrated one. The county has 8,100 Negro children out of a total of some 65,000 school-age children, or less than 5 percent. The county school system has moved toward integration, with about 40 percent of the Negro children in integrated schools.[7]

In May 1960, prior to the opening of the summer program, the parents of Bannockburn, one of the neighborhoods in the vicinity of the Glen Echo Park, passed a resolution at a civic association meeting to be sent to the County Recreation Department, protesting the use of the segregated pool at Glen Echo Park and the separation of the children by race for the purpose of transporting them in school buses to separate pools. In addition, they objected to what amounted to public endorsement of the segregation policy of the Glen Echo Park. Their resolution stated: "Our children are in an integrated school system. The human values we nurture through our schools should be encouraged in out-of-school recreation. The use of segregated facilities by the county is contrary to sound public policy." [8]

The report of this action in the local newspapers caught the eye of the students who had just completed their successful sit-ins in northern Virginia. They set up a picket line on June 30 outside the park and were immediately joined by residents, including adults, teen-agers, and children, from Bannockburn and nearby communities. The picket line was a daily occurrence, with much support from the metropolitan press and from groups in churches, PTA's, political clubs, and so forth. An unwanted feature was a counterdemonstration, much smaller and not too regular, from the American Nazi Party, which carries anti-Semitic as well as anti-Negro signs.

The protests from many people in Montgomery County to the county council re-

[6] "The Politics of the New Negro," *Dissent*, Vol. 7, No. 3 (Summer 1960).

[7] Report of the Montgomery County school superintendent, 1958–59.

[8] Newsletter, Bannockburn Civic Association, June 1960, p. 1. (Mimeographed.)

sulted in the appointment by the council of a seven-man commission on interracial problems, later known as the Commission on Human Relations, to study and make recommendations on discriminatory practices in housing and employment as well as recreational facilities and public eating houses. The pickets at the park together with many community supporters then formed the "Metropolitan Area Non-Violent Group," which continued to picket both the amusement park and a movie theater which refused admission to Negroes. All other theaters were desegregated. The theater was finally sold and later reopened under a nonsegregated policy.

Stubborn refusal by the park owners to modify their stand resulted in a decision by the Montgomery County Council in September 1960 to end use of the park for county recreation programs. It had already endorsed a resolution by its Commission on Human Relations to halt use of public school buses to transport children to the park. In February 1961 the city of Rockville asked the county to share the cost of building a swimming pool that white and Negro children could use together. The council had already instructed its county manager to develop a practical plan for such facilities without regard to color, race, or creed. The issues at park and theater were thus resolved to the general satisfaction of the community, and the County Commission on Human Relations is extending its concern to equality in housing and employment.

There is also community pressure for a civil rights ordinance to give legal underpinning to a desegregated policy. In this total demonstration we can see the ways in which activities on desegregation involve an interracial and neighborhood group and can spearhead community and legal action to safeguard these civil rights. This is not to say that there is no opposition or resistance from various sectors of the county. There are many people who fear desegregation and the new relationships involved. It is well known that not all Negroes are in favor of desegregated facilities. They may fear the adjustment involved in closer association with white people. Similarly, white people have fears —most of them unfounded—of what is involved in even casual association with Negroes at restaurants, movie houses, amusement parks, and even in churches.

One must remember that Montgomery County, with a population of about 400,000, has only 5 percent Negro population in contrast to the neighboring District of Columbia, whose Negro population is over 50 percent.[9] However, the county is predominantly one of white collar and professional workers, federal government employees who are familiar with the nondiscriminatory policies of the federal civil service and government contract laws. It has been said that among the white majority group the middle class is more friendly and sympathetic toward desegregation than the lower class, who are apt to be in competition with the Negro group for jobs and housing and are therefore less friendly toward desegregation.

The interracial picket lines outside Glen Echo Park also illustrate the eagerness of some of the majority group to be active in their support of integration. The preponderance of students made possible a vigorous and energetic endorsement of this cause; it also suggested that they were as yet unaffected by social sanctions stemming from unsympathetic employers.

HISTORICAL SIGNIFICANCE

As social workers, we need to see the current civil rights struggles in historical perspective. It is useful to review briefly the course of racial segregation from the time

[9] Sample survey made by the Bureau of the Census for the District of Columbia government in 1957.

of the Emancipation Proclamation (January 1863) and the Thirteenth (1865), Fourteenth (1868), and Fifteenth (1870) Amendments, which were intended to give the Negro his freedom and the rights of citizenship, including the right to vote. The civil rights bill of 1875 was passed to give the Negroes "full and equal enjoyment of inns, public conveyances, theaters, and other places of public amusement." [10] The intention of Congress to give the Negroes full equality in public life was never actually realized. Even during the years of protection by federal troops in the South (1865–1877) and the benefits of the Freedmen's Bureau (1865–1872), Negroes were harassed by discrimination and segregation. By 1877, after federal troops withdrew, the restoration of white supremacy in the South was accomplished. The Negroes did not have the political power to control legislation to help themselves. The Supreme Court, step by step, invalidated the laws that had been passed for the protection of Negro rights. Barely five years after passage of the amendment, the Supreme Court in 1873 ruled in the Slaughterhouse Cases that the Fourteenth Amendment gave no protection against state laws abridging the privileges of citizens of the United States. In this instance the court made the distinction between citizenship of the United States and citizenship of the states. It held that the United States Constitution cannot be invoked against state laws which violate civil rights. In 1883 it declared the Civil Rights Act of 1875 unconstitutional and opened the way for a series of Jim Crow laws in the states which solidified patterns of segregation and discrimination for the next seventy-three years.

The willingness of Booker T. Washington, according to his speech of 1895, to accept an inferior position for the Negro and to emphasize vocational education as the goal for Negroes encouraged further discrimination. It was closely followed by the Supreme Court decision in *Plessy* v. *Ferguson* (1896), which stated that "legislation is powerless to eradicate racial instincts." This decision justified segregation on the basis of "separate but equal" facilities.[11]

The base was laid for legislating segregated facilities in education, housing, health facilities, transportation, recreation, and in fact almost every aspect of community life. Disfranchisement of the Negro was the next step. One by one the states amended their constitutions to circumvent the Fifteenth Amendment. By 1910 most Negroes in the South were disfranchised. The legally white primary was general in southern states by 1915. The "grandfather clause," [12] the "good character clause," and the poll tax were other devices used to deprive the Negro of his vote. Illustrating the effects of these restrictive measures, in Louisiana in 1896 there were 130,334 registered Negro voters; by 1904 this number had dropped to 1,342.[13]

Signs of reversal trends, however, began to appear. In 1915 a Supreme Court decision invalidated the Oklahoma grandfather clause *(Guinn* v. *U. S.)* and ushered in an era of favorable Supreme Court decisions. Another decision in 1917 held that a Louisville, Kentucky ordinance providing for racial segregation in housing was unconstitutional. The slogan that World War I was a war to make the world "safe for democracy" had a special meaning for the Negro soldiers and helped them develop a greater awareness of individual as well as group identity. The migration of

[10] Arnold Rose, *The Negro in America* (New York: Harper & Brothers, 1944), p. 191.

[11] Rayford Logan, *The Negro in the United States* (Princeton, N. J.: D. Van Nostrand Co., 1957), p. 49.

[12] This exempted from other requirements for voting all descendants of men who had voted before 1867.

[13] C. Vann Woodward, *The Strange Career of Jim Crow* (New York: Oxford University Press, 1955), p. 68.

400,000 Negroes from the South to take up jobs vacated by men who went into service gave real impetus to Negro efforts for greater freedom and opportunity.[14] The experiences available in the North encouraged the great migration to the cities of southern Negroes during the depression. The programs under the New Deal alleviated the poor condition of Negroes, although much more help was needed to strike at the causes of poor health, bad housing, and low income.

With World War II there was increased momentum for moving ahead because of the great need for manpower both in the armed forces and on the factory production lines. Also, the struggle between East and West for a position of dominance required that the United States live up to the American creed of equality and demonstrate to the colored peoples everywhere that discrimination here had been wiped out. In 1948, an Executive Order led to the removal of all discriminatory provisions in the armed services. Starting in 1951, all government contracts forbade discrimination in employment on projects covered by the contract. In 1955 the Interstate Commerce Commission ruled against the segregation of interstate travelers on trains, buses, and in waiting rooms. This ruling followed two Supreme Court decisions—*Morgan* v. *Virginia* (1946) and *Henderson* v. *U. S.* (1950)—which outlawed segregation on buses and trains.

The final blow to the "separate but equal" idea, after fifty-eight years, came with the Supreme Court decision in May 1954 that "separate educational facilities are inherently unequal." The implementation decision of May 1955 allowed time for local conditions and problems, but required action "with all deliberate speed." [15] It is here that controversy still continues, since local readiness for integrated schools is variable. It is partly because of the delay in complying with this decision that other steps, such as the sit-ins, are taken.

IMPACT FOR SOCIAL WORKERS

Social workers are deeply concerned with the injustices of segregation and are caught up both personally and professionally in the many issues and problems involved. Our work in all aspects brings us to a strong realization that as a profession we stand against segregation and for equality of rights. Our individual professional activity may vary widely. We can approach the issue narrowly in our jobs, seeing only the needs of a specific family in our case load. On the other hand, we can develop knowledge of the larger social issues concerned, the community organizations actively working for elimination of segregation, and the legislative processes involved.

Within our own agencies, we can in some way extend the horizon for equal rights. We can raise questions if we find community resources not equally available to all. If facilities for Negroes are less adequate, should we comfortably accept this as the *status quo*? If agency case loads are not yet integrated, what do we do? Are we still struggling with our hidden prejudices? Most of us, as members of a majority group, have absorbed discriminatory attitudes in growing up, and often have little awareness of this. It would require some careful self-scrutiny to sort out these prejudices; and strenuous, ruthless honesty, to admit to ourselves the presence of stereotyped thinking about minority groups such as the Negroes.

Dean and Rosen have found that sustained interaction between majority and minority groups is needed to keep communication and understanding open. This is not a new concept for social workers. We know it well in other contexts. They have also found that workers who are inexperienced in intergroup relations fre-

[14] Logan, *op. cit.*, p. 70.
[15] *Ibid.*, pp. 95–97.

quently alienate persons of the minority by inadvertently expressing themselves in the terminology of prejudice.[16] A basic principle of individualizing the person and being aware of his minority experiences as well as of our own majority experiences will help us avoid the use of stereotypes.

As social workers in any setting, we should know the nature of prejudice, the processes of social change, the elements involved in intergroup relations. In some communities agency executives and agency boards, along with the staffs of health and welfare councils, are called upon as leaders in the community and as persons with know-how in the field of human relations to take an active role in interracial affairs. It has been found that people in strategic positions of authority are able to determine social policy and practices in racial matters. An example is that of San Antonio, where, following the desegregation of the lunch counters, in March 1960 an interracial commission was set up with the executive director of the community welfare council as its chairman.[17] Walter Lurie claims that the policies and programs of social agencies have a powerful impact on the intergroup atmosphere of a community.[18]

The question arises whether social workers are adequately prepared with knowledge and skills in intergroup relations to function effectively as professional social workers in the current dynamic scene. Does this point to the advisability of making a beginning while the practitioner is still a student, by including some content in the social work curriculum—both in class and in field work—in the area of intergroup relations and the development of self-awareness as a member of either a minority or a majority group? There is much that we can do in understanding ourselves and others, and in our many roles as citizens and professional social workers, to further the cause of equal rights. It is expected that we should internalize our convictions about the rights of minority groups, so that our behavior both as private citizens and as professional workers may be consonant with the principles and ethics of our profession. In this sense a demand is made on us for greater personal and professional integrity, to escape the "American dilemma": that of subscribing in theory to our creed of equality, but denying and evading it in practice.

[16] John P. Dean and Alex Rosen, *A Manual of Inter-Group Relations* (Chicago: University of Chicago Press, 1955), pp. 7–18.

[17] Kenneth Morland, "Lunch-Counter Desegregation in Corpus Christi, Galveston and San Antonio, Texas," a report to the Southern Regional Council, Atlanta, Ga. (May 10, 1960), p. 9. (Mimeographed.)

[18] Walter Lurie, "Intergroup Relations," *Social Work Yearbook 1960* (New York: National Association of Social Workers, 1960), p. 313.

BY OTTO POLLAK

Image of the Social Worker in the Community and in the Profession

PEOPLE CONCERNED WITH fund-raising for social welfare, those concerned with recruitment or with referrals, board members, and the workers at their desks are becoming more and more interested in the differences between the image of the social worker as it exists in the community and the image that social practitioners have of themselves. Formulated in such terms, the complexity of the problem does not fully reveal itself. Obviously we would have to ask who the representatives of the community are whose image of social work we have in mind. Do we mean donors to the united fund or to specific campaigns? Do we mean legislators with powers over appropriations, board members, personnel in the co-operating professions, college professors who advise undergraduates with regard to professional careers? Do we mean potential clients, or former clients?

A similar diversity is met when we consider the question of what we social workers think we are. Who is "we"? Trained workers or untrained workers? Employees in public welfare or in private welfare? Caseworkers, group workers, community organization workers? Family service workers, psychiatric social workers, medical social workers, school social workers, prison workers, probation officers? Do we include private practitioners?

Available information is not sufficiently detailed to permit a description of all the various images which these groups of people are likely to have of the social worker. Much that we should know about them has not yet been explored. Much that could be explored if interest, time, and money were available would probably be obsolete ten years after completion of the study. In view of such complexity and such threat of obsolescence, all that can reasonably be done is to identify a few essential elements likely to be found in most images of the social worker held by members of the community and the profession, and the probable changes that these elements of thought have undergone and will continue to undergo in the near future.

WHAT DOES THE COMMUNITY KNOW?

As far as the community is concerned, it should be pointed out that, whatever variations may exist among subgroups, most of them are composed of people who have never received the services that social workers render. This is one of the most glaring differences between social work on the one hand and medicine, teaching, and the ministry on the other. There is practically nobody who in his picture of doctor or nurse, of priest or minister, grade school or high school teacher, would not of necessity draw upon his own experience. With

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lawyers and college professors this is not quite so general, but still much more the case than with social workers. In consequence, the picture of the social worker is more determined by a person's traditional information, which in turn is likely to be colored by his own needs to believe or to scorn than by actual contact with the profession. The traditional items of information that reach a member of the community through newspapers, books, conversational remarks, and solicitors of funds are culturally determined and thus probably much more widely held than people steeped in the culture of the profession are able to believe.

The first element of tradition about social workers is that they transmit to their clients tangible goods. They are visualized as delegates of the community trusted with dispensing charity.[1] The definition of his mandate by the social worker, on the other hand, is much broader. He is inclined to believe that community recognition of the need to provide services is more sophisticated than it actually is. In this respect it is interesting to note three items of empirical evidence. A self study of 500 prisoners at the U. S. Penitentiary in Atlanta revealed that only 38.1 percent knew of any organization concerned with helping prisoners or ex-prisoners. The Salvation Army headed the list, followed by the Osborne Association, churches, car dealers, farmers, the Ford Motor Company, and the Audubon Society.[2] So much for one group of potential clients!

Equally interesting is Margaret B. Bailey's study of attitudes toward help with interpersonal problems. She found that only 39.5 percent of the persons interviewed suggested professional help for child guidance problems, and 32.8 percent for marital difficulties. For the child guidance problems medical and psychiatric help was most frequently suggested, followed in frequency by the psychologist, the clergyman, and the teacher. The social caseworker was suggested by only 4 percent of the sample and ranked lowest among all professional persons mentioned. For marital problems the clergyman ranked first and the social worker again lowest—mentioned by only 3 percent of the sample.[3]

However, in answers to questions about knowledge of community resources social casework agencies were mentioned more frequently than any other types of organized resource.[4] In other words, people in the community were better acquainted with the bureaucratic structure of social work than with the social worker. People may come to the agency or visualize others as coming to the agency, but they do not vizualize themselves or others coming to the social worker as an individual practitioner. Here the lack of a strong underpinning of the community service by experience with private practitioners is obviously an impediment in the formation of a specific image of the social worker as a professional person.

A third item of empirical evidence has become apparent in the course of an as yet unpublished follow-up study of the effectiveness of the training of medical residents for rehabilitation work. In the pretest, sixteen doctors who had received such training were asked if they made referrals to family service agencies. Ten answered in the affirmative and six said that they made no such referrals. Although the figures are small, they suggest at least the possibility that persons in the health-serving professions may have a greater awareness of social workers as a resource for helping people than potential clients themselves. By and large it would still seem fair to say that social workers em-

[1] Harriett M. Bartlett, "Toward Clarification and Improvement of Social Work Practice," *Social Work*, Vol. 3, No. 2 (April 1958), p. 4.

[2] "Project Prisoner," *The Atlantian*, Vol. 18, Nos. 1–2 (Spring-Summer 1959), p. 18.

[3] Margaret B. Bailey, "Community Orientations Toward Social Casework," *Social Work*, Vol. 4, No. 3 (July 1959), p. 62.

[4] *Ibid.*, p. 63.

ployed in public assistance come closer to the image of social workers still traditionally held by the community than family caseworkers, child welfare workers, psychiatric social workers, and medical social workers.

THE COMMUNITY'S VIEWPOINT

This persistence of an oversimplified and sometimes blurred picture of what the social worker does, however, should not be considered only as an item of cultural lag, inadequate ideas, or simply lack of information. It represents that part of the social worker's function which the community is most desirous to see performed.[5] The concept of welfare service is something the private citizen feels as his own obligation and wants to delegate as efficiently as possible. We are agreed in this country that physical wants should be met, independent of income. The American very sincerely and deeply feels what Camus has put into words spoken by a man without professional or religious commitment: "It may be shameful to be happy alone." [6]

We want to see every person happy, but with the reservation that only material unhappiness such as lack of food, shelter, or health is deserving of outside help. Emotional and interpersonal unhappiness the average man feels to be a responsibility for self-repair, and the person who needs outside help in these areas, as well as the one who renders it, is frequently looked upon with disapproval. Paradoxically, it would seem, the part of their work of which social workers are proudest and for which they make the most careful training arrangements is out of tune with the behavioral ideal of many of our citizens.

In this context it may perhaps be helpful to draw a parallel with the field of medicine. In that field, organic disease is accepted by everybody, and the physician serving this area of need is respected by the community as well as by his professional colleagues. The psychiatrist, however, is looked upon askance by many laymen as well as physicians. There is the feeling that he helps people in areas where they should not need help, or should help themselves.

This deep-seated discomfort of the community over helping people with intrapsychic and interpersonal problems is the expression also of another cultural specificity of our American community: the worship of a clear-cut relationship between means and ends.[7] Unfortunately, neither in casework nor in psychotherapy are either means or ends unequivocally given, and a community which glories in the achievements of technology cannot help but question the quality of professional work in which instruments are not employed and the desired results of professional intervention are often difficult to state and even more difficult to assess in the attainment. Therefore, even informed and sympathetic laymen such as board members will welcome effectiveness studies and thereby reveal their questioning of the validity of the service. J. McVicker Hunt's movement scale is perhaps the best-known product of this concern. Yet not only board members but also undergraduates interested in social work sometimes wonder. In her report on a discussion of the two movies, *Diana* and *A Family Affair,* Erma Meyerson has pointed out that the initial reaction of the students was that the worker was doing nothing.[8] That this is a real difficulty will be acknowledged by everybody who reads the ever recurring phrase in recording, "I told her [or him] how we work," and never finds out in what words this was done.

[5] Neva L. Itzin, "Right to Life, Subsistence, and the Social Services," *Social Work,* Vol. 3, No. 4 (October 1958), pp. 3–11.

[6] Albert Camus, *The Plague* (New York: Alfred A. Knopf, 1948), p. 150.

[7] Walter A. Weisskopf, "Industrial Institutions and Personality Structure," *Journal of Social Issues,* Vol. 7, No. 4 (1951), p. 2.

[8] Erma T. Meyerson, "Social Work Image or Self-Image," *Social Work,* Vol. 4, No. 3 (July 1959), p. 69.

Even in services which the community approves without manifest questioning, the social worker's image is affected by ambivalence about helping which can be traced to the impact of Puritanism on our culture. When certain Protestant sects, and Calvinism, began to transfer asceticism from the monastery to the accounting house, and the prudent and diligent cultivation of business activities became a way of praising God,[9] the unavoidable consequence was widespread business success. In a strange psychological transition this result of a religious orientation toward life became a mark of personal worth which Americans even now pursue, frequently without awareness of its religious origins. To be successful is to be "all right"; if you are not, something is wrong with you. In consequence, there is in many members of the community considerable ambivalence about people who, from the point of view of our criteria of valuable personality development, seem to be lacking.[10] We find thus in the community a strange coexistence of two antithetical conceptions: "A view of social services as residual or emergency in nature, reflecting some inadequacy in persons who need them; and a belief that such services are an appropriate, legitimate function of modern industrial society in helping individuals achieve self-fulfillment." [11]

Another interesting phenomenon in American life is the evaluation of professional prestige in accordance with the status of the clients served. The Park Avenue doctor has higher prestige than the doctor in the Bronx, the corporation lawyer more than the criminal lawyer, the college teacher more than the grade school teacher, and so on. Since social workers serve people who are disadvantaged in financial, interpersonal, and emotional respects, the relatively low opinion which the community holds of the client transfers itself to the profession.

From the viewpoint of the co-operating professions, still other things have to be considered. There is, first of all, the length of professional training required. Doctors and lawyers take three years at least; social workers two. To take a third year of training or work for a doctoral degree in social work is a distinction—not a minimum requirement. It is no wonder, therefore, that doctors show higher regard for the professional competence of clinical psychologists than for that of social workers, despite the fact that relationships between psychiatrists and clinical psychologists on the mental health team are often strained, while between psychiatrists and social workers they are usually amiable.[12] Cordiality, however, should not be confused with equality. Nothing is more conducive to the maintenance of pleasant relationships than mutual acceptance of positions of supervision and subordination.

These few suggestions of how the social worker appears in the eyes of the community should not, however, be concluded without identifying the really positive elements. There is, first of all, an increasing recognition on the part of medicine and teaching that they cannot do their work alone. The social worker becomes more and more a part of the resource picture of the physician as well as of the teacher and will in the long run have to be accepted on a footing of equality as a member of the health-serving professions.

Slowly, but with perceptibly increasing frequency, social workers make their appearance in private practice. Thus donors will have more and more firsthand knowl-

[9] Max Weber, *Protestant Ethic and the Spirit of Capitalism* (New York: Charles Scribner's Sons, 1930).

[10] Otto Pollak, "Cultural Dynamics in Casework," *Social Casework*, Vol. 34, No. 7 (July 1953), pp. 279–284.

[11] Harold L. Wilensky and Charles N. Lebeaux, *Industrial Society and Social Welfare* (New York: Russell Sage Foundation, 1958), pp. 138–140.

[12] Alvin Zander, Arthur S. Cohen, and Ezra Stotland, *Role Relations in the Mental Health Professions* (Ann Arbor, Mich.: University of Michigan, 1957), p. 211.

edge of their services rather than having to rely on secondhand information and fantasy. The evaluative studies of casework efficiency have, and are likely to continue to produce, results which will be convincing to people not trained in social work. And preprofessional training of undergraduates in social work is likely to lessen the ignorance of potential students in schools of social work regarding the professional skills and points of view taught there.

NEGATIVE ASPECTS OF PROFESSION'S SELF-IMAGE

As to the self-image of the profession, it is fair to say that it is more negative than the self-image of most other professions. There is, first of all, complaint by leaders in the field about the "inability of the profession to state clearly what knowledge, skill and values are needed for every social worker for basic competence and practice."[13] This is an old complaint, which is increasingly losing its validity. The recent work of the Council on Social Work Education has made great strides toward clarifying the nature and content of the professional functions of the social worker. Further clarification can be expected, since research in social work requires a clarifying of theory and goals which mere practice as such does not seem to have required in the same degree. With the increased demand for social work research, theory will be elaborated, silent assumptions brought out into the open, and social work functions clarified, at least for the profession if not for the wider community.

Another negative aspect of the self-image of the profession seems to lie in the fact that "social work does not exercise clear control over any area which is highly valued by the important, norm-setting members of our society."[14] We have seen that helping the unsuccessful is not something that people in power value without ambivalence in our society. The social worker, being a member of the wider community, will sometimes unconsciously or even at times consciously agree with this generally held opinion, and take the ambivalence into his self-image. When he reads his professional literature he will find his self-questioning confirmed. It is perhaps significant that many papers in the literature of social work are written by persons who by their very function spend their office hours questioning the performance of the practitioner: namely, supervisors, teachers, and executives. Built into the performance of all three, in its institutional aspect, is a screening function that sharpens their perspective for failure and makes professional shortcomings one of their essential concerns.

It should be further noted that the social work executive is not master in his own house. Since, for better or worse, social work is community- or government-supported, it is subject to policy decisions influenced by lay persons often unacquainted with the principles guiding professional practice, who sometimes even hold opinions and make value judgments diametrically opposed to those principles. This in turn cannot help but produce a measure of dissatisfaction with the status of their own profession in the executive group.[15]

As has been done before, attention should be drawn to the implications of the very term "social worker" for the status feeling of the profession. We do not have "medical workers," we do not have "legal workers"; we do not have "theological workers" or "educational workers." The

[13] Harriett M. Bartlett, "Toward Clarification and Improvement of Social Work Practice," *Social Work*, Vol. 3, No. 2 (April 1958), p. 4.

[14] Alfred Kadushin, "Prestige of Social Work—Facts and Factors," *Social Work*, Vol. 3, No. 2 (April 1958), p. 42.

[15] Sue Spencer, *The Administrative Method in Social Work Education* (New York: Council on Social Work Education, 1959), p. 12.

term "work" has a mechanistic connotation. It does not reflect concern with the increase of knowledge on which the professional function is based, does not imply a concept of professional ethics; in short, it is not a professional term. So long as members of the profession see fit to call themselves "workers," they will be choosing identification with an activity or group of activities which has nothing whatsoever to do with the content of their functions.[16] In this connection it is a hopeful sign that the Family Service Association of America has recently issued an official statement recommending that caseworkers designate themselves "family counselors." [17]

Another route of negative implications in the self-image of the social worker seems to lie in the widespread apprehension that they may be seeking to enter the profession because they expect from performance of the professional task a relief of their own unresolved intrapsychic or interpersonal difficulties. Only recently Erma Meyerson has expressed this apprehension.[18] This is an unfortunate value judgment, which should be scrutinized by those concerned with recruitment. It is generally known that self-involvement in professional goals has been a powerful motivating force in the work of many physicians, ministers, and teachers. Why, of all professionals, social workers should be under suspicion because they are not models of perfection in mental health is a value judgment that should be further investigated and probably has some connection with antiquated concepts of supervision. As long as supervisors confused the administrative with the diagnostic function, this overconcern with mental health or its lack in the profession may have been unavoidable. Now that new concepts of supervision as confined to training, administrative control, and task assignment make themselves felt in professional practice, this self-accusation of questionable mental health will probably come to an end.

TRENDS

In closing, three trends may be mentioned which suggest that the negative elements in the self-image of the social worker will lose, if not their content, at least their negative emotional quality. First of all, social work is a bureaucracy. It makes sense that the respondents in the Bailey study were better acquainted with social work organizations than with social workers. Seen in the perspective of the past, this is a failing and leads to self-description in a Parkinsonian mood. Seen in the dimension of the future, this is the organization toward which formerly individualistic professions tend to develop. Group medical practice, large law firms, nationalization of health services, the big city hospitals—all these and many others show that the social worker may have been early on the scene but is no longer alone in his form of organization and is likely to find more and more company from other professions.

The old complaint of not having a specific and clearly identified sphere of knowledge becomes less and less convincing in a time when all established disciplines recognize the need for interdisciplinary integration.

Finally, although social workers may have a poor image of their professional status and performance, rare indeed is the social worker who does not know that there is a personnel shortage in this field. No matter how unsatisfactory public appropriations or the results of fund-raising campaigns may be, social workers know that there are several jobs waiting for every one in the field, and that at present it is the graduate of a school of social work who interviews the agency executives and not the executive who interviews the graduates of schools of social work.

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[16] Pollak, *op. cit.*, p. 283.

[17] Family Service Association of America, "The Future Public Relations of Family Service," memorandum from Clark W. Blackburn to member agencies and premember affiliates, July 12, 1957.

[18] *Op. cit.*, p. 69.

COMMENTS ON CURRENTS

Let's Abolish Commitment Scholarships!

While we are all concerned about the personnel shortages plaguing our profession, we have yet to see evidence that commitment scholarships provide a durable solution to the underlying problem of inadequate supply in the face of ever increasing demand. If our main object is to promote a free and quick flow of talented young people into social work careers, commitments tend to weaken rather than strengthen our efforts. Even a hasty examination of this issue indicates that social work is guilty of a curious sort of double talk. Though we support the principle of freedom of choice for welfare recipients, we often complacently accept—or even abet—work commitment restrictions that hamper the student's freedom to shape his own professional destiny. True, the difficulty of attracting graduates to work in certain areas poses thorny problems. But are commitments really the answer?

Since four out of five students in schools of social work require scholarship assistance, the problem of providing adequate aid is of more than passing interest. While many agencies and welfare councils are generous in supporting scholarship programs, many of their scholarships go begging because their sponsors insist on collecting their pound of flesh by compelling the recipient of their benefactions to work in a specific agency or program for a specified period of time. The value of this approach may be questioned on economic as well as philosophic grounds. Though work commitments may be of limited and transient use in staffing positions, they seem, more often than not, useless in keeping the indentured worker on the job once he has served his time.

If the recommendations of the recently published reports from the Advisory Council on Child Welfare and the Advisory Council on Public Assistance should be translated into appropriate legislation —and ultimately federal grants-in-aid—it is to be fervently hoped that these investments in our public social services will not be marred by noxious commitment clauses. For in many ways the mind-set that fosters the commitment idea is sadly reminiscent of the ancient Poor Law ethic. It does not reflect the highest promise of a free and open democratic society. To the doubting Thomases who say "It can't be done!" we may reply, "How hard have we tried?"

—H. J. P.

Distressed Areas

"I've seen days when this was prosperous. I've seen days when there was 35,000 miners in Fayette County. . . . How many miners are working in the county today? I would say about 1,700."

"We all went through the depression and the biggest majority of us never had an opportunity to get an education so then we had to go into the mines at an early age—15, 16 years old. The biggest part of us are married and if we should leave here now and go to the city, what confronts us? If you're over 35 you can't get a job. And if a man's got a family and he goes to the city, what job can he get if he doesn't have skill?" [1]

During the last few years there has been a striking growth in the severity of local economic distress. Almost 100 areas in many sections of the country have been described by the Department of Labor as

[1] Hearings of the Special Committee on Unemployment Problems, U. S. Senate, October 1959 (Pt. II, pp. 444–445).

having a "substantial and persistent labor surplus." Perhaps as many as 25 million persons inhabit these and smaller areas suffering from chronic unemployment. From a unique and isolated phenomenon, distressed areas have become the major problem of American domestic policy. Migration of industry, technological change, dependence on single industries, inability to compete with areas of cheaper production, shifts in consumer preference, changes in defense programs, all leave large pockets of stranded labor. The dependence of communities on forces outside their control and their inability independently to cope with problems of such magnitude indicate national action.

Aside from sheer economic waste, the social cost of the disintegration of communities and the disruption of individual and family life is immeasurable. The peculiar characteristics of unemployment in the distressed areas accentuate the problem. Adult men, and particularly heads of families, are most affected. These are frequently unskilled or semiskilled workers who have little job mobility, and their general mobility is reduced by their family responsibilities and their inability to obtain adequate wages for the care of their families outside their own community. For these workers, mobility does not mean greater or even equal opportunity, but rather loss of homes and economic deprivation. Opportunities for the young and the older male worker are also reduced; the young worker can find little or no employment where even the residue of part-time employment is based on seniority. In contrast, a greater proportion of women are employed than in other areas. This may be accounted for by the lack of marital and educational opportunities and by the pressures for additional family income.

The Task Force of the Kennedy administration under Senator Douglas has already made broad recommendations of national policy. These include a variety of measures: distribution of surplus foods, extension of unemployment benefits, federal participation in financing general assistance to the families of unemployed, public works projects, loans and grants for the encouragement of economic redevelopment, defense contracts. In addition, the Task Force recommended the general improvement of the level of education, vocational training, retraining, counseling, and placement. Except for the public assistance, unemployment compensation, and general education provisions, the Douglas bill (S1) and its counterparts in the House contain the major suggestions of the Task Force report. The other provisions are to be introduced in separate legislation.

The Douglas proposals are a sound beginning for dealing with the problem, but a more long-term and broad-gauged approach is required. The appropriation requested in the Douglas bill, less than $400 million in loans and grants for stimulating new economic developments, is small by comparison with the number of areas involved, and less than one-third of this money is to be made available before July 1, 1962. The question of what is to be done with areas with little industrial potential of their own still exists. While improving the situation in distressed areas will affect the total economy, a general increase in the growth of the total economy is necessary if the distressed areas are to be absorbed in an expanding economy rather than merely brought up to the general level of employment through continual emergency measures. Long-range policies are needed to deal with the chronic causes of distressed areas and with the human problems involved. Individual family security and community stability are threatened by recurrent local crises which entail either stagnant despair or random migration. As the President's Task Force concluded, "consideration must be given to the structural changes in the economy which produce unemployment with particular emphasis on automation and . . . [to] the job of devising . . . an early warning system together with remedial measures." —S. M.

POINTS AND VIEWPOINTS

The Need For Family Planning

In recent years the question of family planning has moved from private discussion and individual choice to large-scale investigations by social scientists and to controversy in the arena of politics and the courts. World-wide recognition has been given to the adverse relationship between unhampered population growth and economic development. Yet American social workers, who would seem to be in a strategic position to observe the impact of unwanted children on the diverse problems of their clients, have permitted sociologists and economists, gynecologists and physiologists, ministers and politicians to pre-empt their chance to contribute useful insights on this subject.

This is not the place to analyze why social workers by and large appear to have focused their concern on other aspects of family welfare. Instead, we shall refer to some findings of three independent investigations which, taken together, should direct attention to the difficulties many clients encounter in this sphere.

Family Planning, Sterility and Population Growth—a survey of the family planning patterns of a nationwide sample of white women of child-bearing age—is by far the most comprehensive and systematic of these studies.[1] Its findings may have a bearing on future social policy, *e.g.*, in school and housing programs, on both federal and local levels. Professor Freedman and his coworkers discovered that in the mid-fifties the "ideal" family size in the United States includes three to four children, with relatively small variations in the number of children preferred by respondents in different social, religious, or occupational groups. A growing majority of American families already has or anticipates having children within this desired range. About 95 percent of all women interviewed were using, or had used, some form of contraception. What interests us here, however, is that women with less than grammar- or high-school education appeared less able to keep their family within the desired size than those with more education and commonly larger family income. Not surprisingly, the former were found either not to use contraception at all or else to do so haphazardly, belatedly, and ineffectively. Thus the families least able to support many children were the ones most likely to show excess fertility, at present and in the future.

Dr. Rainwater and his associates have also done some intensive interviewing of 50 couples of an educational and economic status comparable to this excess fertility group in the Freedman study—*i.e.*, unskilled and semiskilled manual and service workers—to explore the reasons for this gap between ideal and actual family size among them.[2] [Their findings are discussed elsewhere in this issue. See p. 117 ff. Ed.] The authors conclude that the majority of these couples, in particular the women, are indeed motivated to limit the number of their children. Yet their style of life makes effective contraceptive practices difficult to achieve.

The authors do not foresee any easy solution, even if the famous "birth-control pill"

[1] By Ronald Freedman, Pascal K. Whelpton, and Arthur A. Campbell (New York: McGraw-Hill Book Company, 1959).

[2] Lee Rainwater, assisted by Karol Weinstein, *And the Poor Get Children* (Chicago: Quadrangle Books, 1960).

in its present form were to become generally available. They suggest more education and publicity at a level appropriate to this group. They stress that professional workers in and out of Planned Parenthood clinics should tailor their advice and the choice of contraceptive recommended more closely to the specific needs and values of these families rather than repeat prescriptions to middle-class patients. In this they do not address themselves as much to social workers as to doctors and public health personnel. It would seem, however, that workers in family and children's agencies are often in a favorable position to clarify some of their clients' ambivalent feelings which have been found to impede their family planning goals.

The important role of social workers in this context, in both public and private agencies, also became apparent in a much less ambitious study of unwanted pregnancies among a group of 25 long-term relief clients with children.[3] This investigation (in which the writer participated) was undertaken as part of a larger study and demonstration project for hard-core relief clients in a midwestern county. We wanted first of all to discover the incidence of such pregnancies among these families, and found that for our representative sample of long-term relief recipients, about one-third of their total pregnancies could be considered unwanted. Almost all of these unwanted pregnancies occurred *after* the first contact with the welfare department.

We then proceeded to explore the impact of these unwanted pregnancies on the lives of the clients. A few of our findings are summarized here:

1. Serious health hazards or impairments existed among one-fifth of these women prior to their fourth confinement, and in about one-half of the group subsequent to their fourth confinement. These additional pregnancies also tended to aggravate existing health impairments, although no complete physical breakdown could be attributed to pregnancy-connected causes alone.

2. Already severe emotional strain was worsened by the onset of another pregnancy in several instances.

3. In about one-fourth of the cases serious marital problems could be attributed in part to the wife's concern for her health or fear of other problems in the event of another pregnancy. For 9 couples this marital discord eventually led to temporary desertion, often at the time of the unwanted pregnancy; for 4 this led to permanent desertion or divorce. In several instances, the husbands came in conflict with the law during these episodes.

4. Several pregnancies occurred while the husbands were suffering from long-term disablement and unable to support their families. For 11 families, additional children aggravated already seriously overcrowded and substandard housing conditions. Otherwise, the material standard of living of families already on relief or ADC hardly suffered by an increase in the number of children, but once their family included more than 4 or 5 children it became increasingly difficult for them to become self-supporting once again and to remain so once they had obtained employment. With the smaller families, difficulties arose not so much because their already marginal income became inadequate to feed additional mouths, but rather because the loss of the wife's earnings reduced the family income below minimal needs. We found no evidence in our records that any of these women chose to become pregnant in order to qualify for either relief or ADC benefits.

5. The majority of the children born from unwanted pregnancies along with their siblings received as good care as their parents could be expected to provide. However, in over half the group some children presented serious learning, behavior, or health problems; some required psychiatric

[3] Gitta Meier and Iris Littig, *The Effect of Unwanted Pregnancies on the Relief Load* (New York: Planned Parenthood Federation of America, 1959). (Mimeographed.)

attention and commitment to an institution. In at least 5 families—all with 5 or more children—serious and continuing neglect was also evident.

At least half these clients are known to have expressed interest in limiting their family size in the course of their contacts with welfare department and other agencies; the possibility of sterilization was brought up by either clients or workers as a measure of desperation in 6 cases, but performed for only 1 woman after her sixteenth confinement. Here, too, the apparent failure of these families to turn their wish to avoid further pregnancies into effective prevention can be accounted for by inadequate information and insufficient motivation. We believe that other extraneous factors also contribute to these results: the policies of the visiting nurses in the county forbid contraceptive counseling unless specifically requested by a woman; the only inexpensive prenatal clinic is connected with a Catholic hospital; other physicians' prescriptions against additional pregnancies apparently were either not understood or else were made in terms impossible for these women. Referral to the local Planned Parenthood clinic were made either much too late in the women's reproductive life or under special circumstances unfavorable to compliance. No follow-ups on these referrals took place.

We also looked at these findings from the point of view of expense and effort to public and private community agencies. As a group, these families had a very high rate of contacts with various social agencies, some of which could be directly related to the problems discussed here. For the welfare department alone we estimate that elimination of most of these unwanted pregnancies might have saved the department at least one-third of all pregnancy-related medical expenses and hospital bills (in spite of Blue Cross coverage for a good share of them). The savings in direct relief are more difficult to calculate but would have been not inconsiderable, since financial assistance was eventually required in most of the circumstances described above.

What can we conclude from these investigations? Perhaps the eagerness and frankness of the respondents, which came as somewhat of a surprise to the investigators in the first two studies, is as important to social workers as their substantive findings. The women interviewed were found to be most willing to discuss these highly personal subjects and anxious to receive more information about contraception. (Some of them considered questions about their income too personal!) This should encourage social workers to discuss family planning with their clients—just as they might the need for regular health check-ups or school attendance for their children—*before* these families have grown to the size at which contraceptive efforts are apt to be unsuccessful and it is very difficult to remain self-supporting on a marginal income. In most communities social workers happen to be among the few professional people having routine contacts with families in the lowest socioeconomic group which permit this kind of counseling.

To add this particular concern to their manifold responsibilities may at first appear to be wasting staff time on matters not of primary concern to the client's business with any social agency and to require even more hours spent on referrals and follow-ups. Yet it would seem that for most agencies these demands would be easily balanced by savings on long-term services and expenditures necessitated by the after-effects of unwanted pregnancies, whose incidence should be reduced in this manner to a more tolerable proportion of all pregnancies. Many serious health, marital, and financial problems might be prevented. It remains up to them to put at the disposal of their clients the knowledge and services related to family planning that are now available to the more privileged and better-informed segments of our population.

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BOOK REVIEWS

And the Poor Get Children

The problem of the world's "population explosion" has begun to intrude itself into popular consciousness even in Western countries blessed with relative economic abundance. The general reaction to this grave problem remains a remarkably ethnocentric one—it is a problem considered urgent for others to take hold of immediately, be they other classes, nations, or races.

Lincoln Day, a demographer, calls this attitude our double standard of population growth: condoning our own, condemning increases elsewhere.[1] It is not generally known that the rate of population increase in the United States since World War II is greater than that of the high density population areas in several Asian countries.[2] Thus, for example, our population increase of 25 million in the last decade did not even make headlines, let alone being viewed with alarm. This casual attitude might well be called social irresponsibility—all the more so since our population is a heavy consumer of the world's productivity and natural resources. Thus, with about 6 percent of the world's population, we consume about 50 percent of the world's production of basic raw materials. In more prosaic terms, what one U.S. citizen considers necessary to the maintenance of the "good life" would maintain thirty individuals in India at their present standard of living.

Most considerations of population growth seem to be limited to the question of mere survival and the staving off of hunger. The fact is that nearly 75 percent of the world's population does not have enough to eat. Many even well-informed individuals remain remarkably sanguine and optimistic regarding the miracles of scientific technology and the unlimited bounty of the earth. In a country obsessed with self-imposed diets, it is easy to reassure oneself about the nutritional wonders of seaweed. Social workers as a profession have a positive concept of the "good life" which includes personal dignity, opportunities for growth, and creative functioning. Such a concept of social opportunity and participation takes more than providing 1,000 calories per day. How can we keep up with the demands for housing, health, and education—to name a few basic needs—even in a country with our basic wealth, when we must plan and provide for 25 million new people within a decade?

It is hard to predict when this problem will become a high priority for social policy formulation. When it came to the fore on the international level in connection with foreign aid, we beat a hasty retreat. This is not surprising, for in addition to many other complex factors, it is clear that the problem is not really studied in our own country, but remains shrouded in numerous taboos. When it is eventually tackled as a social policy issue, the key question to emerge will be how to translate social policy into individual will and behavior. This is a troublesome matter, as witness our current struggles with desegregation. More research is needed as a guide to ways of altering attitudes and behavior in populations—the kind of basic knowledge required for any effective preventive activities.

Dr. Lee Rainwater's study, assisted by Karol Kane Weinstein, of what makes for effective contraceptive practice in the

[1] "The American Fertility Cult: Our Irresponsible Birth Rate," *Columbia University Forum*, Vol. 3, No. 3 (Summer 1960).

[2] Norman St. John-Stevas in *Birth Control and Public Social Policy*, a report of the Center for the Study of Democratic Institutions, lists the annual increase in population in Asia as 1.7 percent, in the U.S. as 1.8 percent.

working class (*And the Poor Get Children*, Chicago: Quadrangle Books, 1960) is a solid contribution to knowledge of psychosocial factors that determine attitudes and behavior regarding family planning in the lower class, as defined by Warner. A sample of 96 working-class men and women of various religious beliefs was interviewed at length. In contrast to previous studies, this one links social stratification and class attitudes with sexual sentiments and patterns, in both social and intra- and interpersonal contexts. As a result, we have some increased understanding of the reasons for failure of the lower class to become successful contraceptive users.

The working class has the greatest difficulty with family planning. Contraception is used least often, or is used late in the child-bearing history. Even when used, there is the greatest failure to achieve the goal. A typology is evolved: there are early planners, who resemble more the middle class in orientation; there are the "do-nothing group," the sporadic users, and the late, desperate users. The last two groups are of particular concern to family planners. The families have some knowledge and some motivation, but fail in execution. What are the factors that prevent successful family planning in the lower class?

The study makes the trenchant observation that failures at the interpersonal level are more common than technical failures in the use of appliances. Effective personal planning of any kind requires a basic value orientation in which an individual views himself as an effective agent in the control of his own destiny. It requires a futuristic value orientation in which trust is central in the view that the future is predictable. Moreover, the sense of hope must abide if immediate pleasures are to be postponed for future gains. Such sentiments are slight or absent in the lower class. These concepts have been evolved in other contexts by Spiegel, Erickson, and French, and are brought to bear in this study. Thus, family planning is viewed as an ego function. Planning requires an integration of values, needs, and goals which taxes the organizing and executive capacities of the ego. It requires a concept of choice and the assumption of responsibility.

Another dimension explored is the interpersonal one in which social role factors predominate. The study describes the lack of emotional closeness characteristic of lower-class marriages and the heavy factor of reversal of role expectation. Thus women want more affection from their husbands, while the men value most highly the homemaking and mothering contribution of their wives. The chief failure is on the level of communication, generally, but especially regarding feelings of intimate and sexual matters. In contrast to commonly held stereotypes, there is more sexual inhibition than sexual freedom; more guilt as to premarital sexuality; and considerable lack of sexual knowledge of cause and effect, physiological structure and functioning. These facts are linked to behavior. For example, when there is high ambivalence or outright rejection of sexuality, the women will refuse to use feminine appliances that require manipulation of their organs and will project total responsibility for contraception on the husband. Similarly, although the condom is the most frequently used appliance in the lower class (the diaphragm is a middle-class appliance), the men tend to associate it with premarital activities and the prevention of venereal disease, and thus it becomes taboo for use in marriage. The study comments on the use of an oral pill —generally held to be an "answer"—with the pessimistic prediction, based on investigation, that it arouses anxieties of being desexed, sterilized, or poisoned. This suggests that not only the simplicity or the availability of the device, but sentiments and individual fantasies and feelings stand in the way of its use.

The findings of the Rainwater study are congenial and important to both the clinician and the social planner. Because

of its multidimensional nature, it offers insights useful to social workers beyond the immediate issue of family limitation. Many of the characteristics and attitudes identified in this study are highly pertinent to all social work activities with lower-class families, where divergent cultural attitudes and value orientations between worker and recipient impose barriers to successful use of social services. This reviewer has learned unofficially that the authors may replicate the study with a broader sample including Negro lower-class families. Such further studies with a greater number of ethnic groups are to be encouraged. A challenging social need can move to a sound action program only when planners are fortified with valid knowledge and insights provided by such studies as this.

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PATTERNS OF CHANGE IN PROBLEM FAMILIES. By L. L. Geismar and Beverly Ayres. St. Paul, Minn.: Greater St. Paul Community Chest & Councils, Inc., 1959. 48 pp. $2.00.

This study of the change in social functioning of 150 families in the St. Paul project which had received at least nine months of family-centered treatment includes a description of fifty-five of these families two years after closing and an analysis of family-centered treatment for a random sample of thirty of them.

The major interest of the researchers was in evolving a method of evaluating changes in a multiproblem family during the course of social work treatment.

The authors developed rating scales for measuring nine areas of social functioning in a hierarchy and used these instruments to examine the family functioning at intake and at closing. As a group, these families revealed a similarity in their pattern of functioning at closing to that at intake. "Basic problems faced by the family at intake remained basic problems, actual or potential, though of lesser intensity." The authors point out that they are speaking of average, not individual, cases. The typical pattern of change is one of slight modification of social functioning rather than marked improvement, especially in the more problematic areas. It was also found that the gains made during treatment tended to be sustained during the two-year follow-up period.

Questions of the validity of the findings will be raised by research workers. In establishing that change took place, a group can be measured against itself, but to establish the part played in the change process by particular factors a control group is needed to hold the factors constant. This the authors acknowledge: "Scientific measurement in the social sciences requires the use of control groups." They state they were unable to set up such a group. They consider the gains made and sustained to be movement—but can this improvement actually be attributed to family-centered treatment? Again, the authors make clear that they prefer to state that movement occurred during treatment. This report also focuses on certain tangible evidences of improved social functioning which are visible to the community, such as reduction of public assistance costs and of officially reported behavior disorders in both adults and children, and it recognizes the complexity of measuring these indices.

The need to search for causation of severe deterioration in families is acknowledged, even though this study was not designed to explore causation. Many of the families, however, had early contacts with social agencies. In a previous study the researchers found that the shorter the time span from marriage until application for agency help, the greater the family disorganization at a later period. Although the data in this study were not statistically significant, they supported previous findings.

The analysis of the use and outcome of family-centered treatment techniques in the thirty cases focuses on certain pro-

cedural measures, such as going out to a family which has not requested service and defining the problem; home visits; and co-ordination of community services by the worker. When the content of interviews was examined, it was found that four out of nine topics accounted for 71 percent of the subjects covered. These four topics were: individual behavior and adjustment, family relationships and unity, economic practices, and use of community resources. The topic of care and training of children occupied a middle position, with about 6.7 percent of discussion time devoted to this area. Findings with regard to the association between subjects discussed and movement suggested that marked differences existed in the extent to which the problems discussed in interviews effected change in functioning.

Many caseworkers will miss reference to the dynamic aspect of the treatment experience for these families. While there is emphasis on such matters as persistent marital conflict and the father's relatively weak role, there is limited reference to clinical aspects of the work with these families and to a differential treatment approach based on psychosocial diagnosis. Diagnosed psychosis or character disorder occurred in fewer than 10 percent of the men and women in the families. Emotional disorders were suspected, however, in other cases.

In conclusion the authors note that many more questions were raised than answered by the findings. One such question relates to the fact that 16 percent of the families deteriorated in social functioning from intake to closing. Can we proceed further to identify which families are going to show a continuing downward spiral of deterioration as well as which will improve in social functioning?

The study is provocative and the researchers are to be commended.

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ORIGINS OF ALCOHOLISM. By William and Joan McCord, with Jon Gudeman. Stanford, Calif.: Stanford University Press, 1960. 193 pp. $4.75.

The Cambridge-Somerville (Massachusetts) Youth Study was established by a Harvard professor in 1935. Information was sought on delinquency prevention and encouragement of character growth in a comparison of 325 boys to be given medical and educational assistance as well as regular attention from social workers, with a matched set of 325 to be left to the usual services of the community, these latter to serve as a control group. From the data thus compiled over the years, the McCords have drawn an interesting study of alcoholic addiction. The longitudinal character of the study is its chief claim to significance. And if it produces few final conclusions which are more than tentative, and approaches gingerly the subject of the causation of obsessive alcoholism, this is inevitable in any responsible assessment of so subtle and elusive a social phenomenon.

This book would seem to have a particular value for persons engaged in social work, not only because of the data bearing on the matter of Cambridge-Somerville environmental factors and their indicated influence on later alcoholic addiction, but also for its discussion of alcoholism causation as generally and historically viewed from the several slants of the biologist, psychologist, sociologist, *et al.* It is an able summarization of literature on the subject, and though the range of specialist views somewhat suggests the fable of the blind men describing the elephant, a certain synthesis of this babble with the study findings is suggestive at least concerning the nature of the problem.

One could wish that the longitudinal dimension of this study were matched by greater breadth, since in some of the data breakdowns to measure the effect of specific environmental factors any conclusions rest on a rather slender basis. As for the principal element in this sifting down, stated in terms of dependency need and confused self-image, the confirmative case is the more persuasive for being moderately urged.

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EPIDEMIOLOGY AND MENTAL ILLNESS. By Richard J. Plunkett and John E. Gordon. New York: Basic Books, 1960. 126 pp. $2.75.

This sixth monograph in the series published by the Joint Commission on Mental Illness and Health is an analysis of the applicability of the science of epidemiology to the problems of mental illness. Epidemiology is defined by the authors as "a body of knowledge about the occurrence and behavior of disease in populations and, also, a method of study to determine causes and courses of diseases affecting the individual and the community."

In what areas does this information contribute to the social worker's knowledgeable handling of individual and social problems? First, an accurate count of the number of mentally ill and their distribution in the population, and a reasonable expectation of the rate of occurrence, should help in planning for community and individual services. The authors estimate that 17,500,000 Americans suffer from mental illness severe enough to warrant treatment in the course of a given year, yet only 10 percent are recognized. The 90 percent who are unrecognized and untreated not only suffer as individuals but limit our understanding of the extent and nature of the problem and hamper our efforts toward control and prevention of mental illness.

Further knowledge of the characteristics of the mentally ill population should offer more clues to the understanding of mental illness and the planning for its treatment and prevention. The relationship of in-

dividual and environmental variables as studied in the mass may highlight characteristics of disease and perhaps even patterns suggestive of causal relationships.

The authors emphasize the current rudimentary nature of the application of epidemiologic methods to the study of mental illness. The difficulty of achieving unanimity in clinical diagnosis, in addition to existing differences of nomenclature, offers major obstacles to the epidemiologists. Sources of information, methods of procedure, and a brief survey of epidemologic research are included in the volume.

The authors state their belief that "continued epidemiologic progress in the field depends on the construction of orderly well-controlled field experiments designed to identify and quantitate, one by one, the various factors that have been advanced as being involved in causality." They suggest epidemiologic analysis of suicide, alcoholism, *postpartum* psychosis, and psychosomatic disorders as suited to this scientific method.

Drs. Plunkett and Gordon ask for close co-operation with public health and other helping agencies in overcoming the obstacles standing in the way of effective epidemiologic surveys. They emphasize that mental illness "must be understood in the individual before it can be dealt with in groups of individuals and populations on the public health level."

This monograph is a well-written, cautious, brief statement of the principles of epidemiology and its application to the study of mental illness, and is a reminder that the search for causation of mental illness demands an intensive scientific study of the individual and of his social environment. It is unlikely that either one will yield answers unless studied in interaction with the other.

ELEANOR CLARK
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THE CITIZEN VOLUNTEER: HIS RESPONSIBILITY, ROLE AND OPPORTUNITY IN MODERN SOCIETY. Edited by Nathan E. Cohen. New York: Harper & Brothers, 1960. 267 pp. $4.75.

Setting forth the significance and varied aspects of volunteer service on the American scene—its historical perspective, motivation, and examples of current practice in special fields—Dean Cohen and other contributors direct their task to the "right utilization of this great social asset."

The book consists almost entirely of articles by professional experts from journalism, sociology, social work, voluntary and governmental agencies, hospitals, and fund-raising and volunteer bureaus.

Against an historical and philosophical backdrop of the importance of citizen participation in a democracy (the *what* and *why* of voluntarism), the *where* and *how*—or the roles of volunteers in programs concerned with the physically and mentally ill, with youth and the aging, with intergroup relations, fund-raising, and the national community—are realistically delineated. A description of the function and operation of volunteer bureaus (directory appended) adds another dimension.

Concluding articles, "The Volunteer and Social Change" and "What of the Future?" are especially timely and provocative in their treatment of today's issues and trends and their impact on our social structure in general—in particular, on the "efficacy of our voluntary structure, with its potential as a training ground for citizenship."

Although this is written primarily for the volunteer, seasoned professionals, students entering helping professions, and those otherwise concerned with citizen participation in community programs will find *The Citizen Volunteer* a valuable volume, both stimulating and rewarding.

Saddle-sore veteran volunteers may quibble a bit about what sometimes seems ambiguous terminology, especially in relation to "voluntary associations" and what com-

prises membership in them; the validity of certain points in motivation analysis as a basis for recruiting and maintaining citizen support; or the fact that more fields of service are not covered or more material from volunteers themselves included.

But this would be to miss three important points:

1. The book is "the product of many collaborators and does not (necessarily) represent a single point of view"—albeit the acceptance of basic principles underlying volunteer service is almost unanimous.

2. Volunteers have been talking about these basic principles for a very long time. It is appropriate and encouraging that so many distinguished professions are talking about them, too—and in print!

3. Although the contributors deal, for the most part, with the *status quo* of volunteer service, the presentation of changes now in process in modern society challenges any smug assumption that even maintaining the *status quo* can be taken for granted.

Concern, conviction, creativity, and new and energetic patterns of action are called for to develop the kind of citizen volunteers Dean Cohen calls the "backbone" of our democracy. "If ever there was a time to seek ways of greater participation . . . that time is now."

THELMA SHAW
Fairmont, West Virginia

ADOPTION OF ORIENTAL CHILDREN BY AMERICAN WHITE FAMILIES. An Interdisciplinary Symposium. New York: Child Welfare League of America, 1960. 66 pp. $1.00.

Intercountry adoptions are still new enough to be constantly scrutinized from the point of view of both practice and result. Of particular interest is the placement of children of a racial background different from that of their adoptive parents. When the refugee situation in Hong Kong became so desperate that the lives of the many abandoned or orphaned Chinese children were at stake, the International Social Service increased its efforts to find adoptive homes for these children with families in the United States. Surprisingly, more Caucasian families than Chinese seemed eager to adopt these children.

Because ISS found itself working increasingly with these interracial placements, the agency invited five eminent scientists to meet with the ISS staff and a small group of caseworkers from other agencies to consider together the implications of such placements and to seek better understanding of the complex considerations that must go into the social evaluations of these adoptive arrangements.

Mrs. Henrietta Gordon, Director of Publications for the Child Welfare League of America, was the summarizer for the symposium and also assumed the task of editing the recorded proceedings for publication. One cannot help but feel a touch of sadness when one realizes that this publication came off the press just a day or two before her sudden death.

The reviewer believes that the contents of this publication are rather unique in social work literature and will be helpful to anyone working in the adoption field or with racially mixed children and families. Questions of the distinction of Oriental traits, parental identification, the genetic results of intermarriage, awareness of cultural heritage and pride, acceptance in the community, conflicts within the child, and many others are explored. While the symposium does not presume to have all the answers, the proceedings provide enough scientific confirmation of the soundness of placements of Oriental children with Caucasian families to make valid a continuation of the practice.

The last paragraph of Mrs. Gordon's summary is well worth quoting here: "When we become a human family in which the superficial differences are insignificant, when in fact, we can accept each other as human beings with similar hopes and aspirations, then the adoption of a child into any family will create fewer risks than it does today."

SUSAN PETTISS
International Social Service
New York, N. Y.

THE SELF-IMAGE OF THE FOSTER CHILD. By Eugene A. Weinstein. New York: The Russell Sage Foundation, 1960. 80 pp. $2.00.

This small volume reporting a study conducted while the author was a Russell Sage Fellow at the Chicago Child Care Society is a significant addition to the growing evidence that useful research results from the collaboration of social scientists and social work practitioners.

Dr. Weinstein, currently associate professor of sociology at Vanderbilt University, conceives of the placement situation as a social system made up of four positions—child, natural parent, foster parent, and agency (as represented by the caseworker). The report involves responses from 61 children from ages 5 to 14. All had been in foster care for at least one year. Children who were seriously disturbed emotionally were excluded from the study.

The author asked each child twenty open-ended questions in a semistructured interview. The same interviewer for all children provided a degree of control not otherwise possible.

The report is clear and concise. No special knowledge of statistics is necessary to understand it. Major conclusions include: (1) older children have a clearer perception of foster status than do younger ones; (2) children seem better off with a strong identification with either foster or natural parents than with a mixed identification; (3) visits are very important to maintaining identification with natural parents; (4) children seem to identify more closely with foster mothers under age 45, perhaps because younger mothers treat them more as if they were adopted; (5) in this sample the relationship with the caseworker is most significant in times of crisis or imminent change; (6) children who had lived in several different foster homes tended to have a better understanding of both foster status and of the function of the agency.

This study helps to establish the meaning of foster care to the child. Its findings are logical, without exception. Since the study is easily replicated, it would be most helpful if several other agencies would test Weinstein's generalizations and would include some children with varying degrees of emotional disturbance. Also of interest would be further study of children termed in the report "semi-adopted"—those in long-term foster care who have little contact with natural parents and remain in the same foster home.

DONALD BRIELAND

Elizabeth McCormick Memorial Fund
Chicago, Illinois

SEX OFFENSES. "Law and Contemporary Problems," Vol. 25, No. 2. Edited by Melvin G. Shimm. Durham, N. C.: Duke University School of Law, Spring 1960. 160 pp. $2.50.

This issue of the quarterly is a symposium designed to examine the social control of unconventional sex practices. According to its editor, the contributors have sought to survey and analyze the "crazy quilt" of laws governing sex offenses in the United States by assaying their validity from the anthropological, ethical, sociological, psychiatric, and biological points of view. Additional special attention is given to the juvenile ("The Marginal Status of the Adolescent," by Albert J. Reiss), and two contributors provide a summary description and appraisal of British and Scandanavian experience.

The basic purpose of the issue is to gain popular support for a sounder, more rational, and more humane resolution of this particular problem through a consistent framework for the criminal law regarding sex offenses as proposed in the American Law Institute's model penal code. More concretely there emerges the concept that the criminal law should punish only acts that are socially dangerous, independent of their moral character, and ignore sexual acts that are adult, private, and consensual. Acts considered socially dangerous are those with persons under the legal age of consent, those judged to be a public

nuisance or infringement of public decency, and those involving force, duress, or fraud. Social workers in the correctional field will be particularly interested.

It is perhaps unfortunate that each contributor does not speak more directly to this theme. The symposium is a somewhat confusing collection. An exposition of the holophilic theories of Freud, for example, follows a sociological consideration that questions giving attention solely to psychogenic factors. Identical studies on sexual behavior are separately considered and analyzed in several of the articles. Yet the "crazy-quilt" pattern of our criminal laws is made clear. The existence of social controls apart from the law is documented. The overlapping province of law and morals is consistently analyzed. Evidence is presented questioning the basic assumption of the sex psychopath statutes that sex offenders are a special breed of criminal requiring unique laws and special administrative procedures for their control. Reiss's consideration of the anomalous position of the adolescent in juvenile courts and training schools is superbly done. In any event the reader will emerge with the conviction that the movement for a rational framework for the criminal law regarding sex offenders is long overdue, and that he should join the efforts to forward this cause.

C. WILSON ANDERSON
Commissioner, Office for Children and Youth
Department of Public Welfare
Commonwealth of Pennsylvania

JANE ADDAMS: A CENTENNIAL READER. Edited by Emily Cooper Johnson. New York: The Macmillan Company, 1960. 330 pages. $6.00.

During the past centennial year of Jane Addams' birth, there were bound to be some outside the field of social work or, like myself, beginning in it, left slightly puzzled and wearied by this chorus of eulogies. One may suspect that this attitude stems from a lack of knowledge about Miss Addams, for while many know her name in connection with Hull House and early urban and industrial reform, fewer realize the breadth of her activities and concerns. I can think of no better book to fill this gap of knowledge than this collection of Jane Addams' own writings. In reading them, one is continually impressed by the clarity of her thinking, her sense of humor, the richness of her sympathies —above all, her commitment to a vision of the truth which affirms that that which unites men is greater than all that divides them.

It is true that some of the problems about which Jane Addams wrote—the sweatshop system, factory conditions, the inferior rights of women—are no longer with us to the same extent or in the same form. Yet today's immigrants continue to crowd into inadequate city housing and to encounter economic and social discrimination, and there is still a problem of youth on the city streets. We have not yet discovered how best to develop that potential for living, the "opportunity for varied and humanizing social relationships" which Jane Addams saw in the city, and the world seems farther than ever from resolving the conflict between welfare and warfare, between internationalism and narrower loyalties, that tears it apart. What Miss Addams thought and wrote has relevance for us today, and as social workers we can learn from her—to look again at social work as a force for education and social action, to re-examine the meaning of democracy and the "democratic process," and, not least, to nourish in ourselves that "passion for the equalization of human joys and opportunities" which is the passion for justice, and which Jane Addams possessed to such a degree.

CAROLA TEEGEN
Student, University of Chicago
School of Social Service Administration

LETTERS

RESIDENTIAL TREATMENT

For those of us working in the field of residential treatment of emotionally disturbed children, it was indeed pleasing to read three different articles pertaining to that field.

We were particularly interested in the article, "Life-Space Management of Behavioral Crises." Being somewhat familiar with the setting and the real competence of the staff, we wondered, though, why there were only "token" comments concerning the attitudes and feelings of the staff. Certainly the reactions of the staff would have some significant relationship to the reactions of the youngsters. We are convinced that help would have been available to the youngsters only if the staff had, to some significant degree, resolved their own feelings about the closing of the Children's Treatment Residence. Was the morale of the staff low because of the intense "acting-out" or was it a combination of the children's behavior and the staff feelings about the residence closing? The article would have had more meaning and depth had there been further explanation of this facet of the problem. The article does, though, represent another important contribution by the National Institute of Mental Health.

Again, we are pleased that the journal is so obviously interested in such a specific service, but one that is contributing so very much to our understanding of human behavior.

RALPH SHERMAN

Executive Director
Lad Lake
Dousman, Wisconsin

BOARD MEMBERS ARE HUMAN, TOO!

Congratulations to Mr. Auerbach for his very excellent article on the motivations for participation on the boards of social welfare agencies. His analysis helped clarify the hitherto unfocused ideas and concerns which I suspect come to most social workers who deal with boards.

Perhaps our discomfort in recognizing our own needs for recognition and status has made us tend to reject, as unsuitable, those very same needs on the part of our board members.

SERAPIO R. ZALBA

Executive Director
Northern California Service League of San Mateo County
Redwood City, California

. . . FORTITER IN RĒ

On behalf of the Joint Committee, of New York State Chapters, NASW, I wish to express my strong appreciation for the publication of "The California Story." For many years, those of us interested in legal regulation of social work have watched the experiences of professional social workers in California with considerable interest. Publication of this article helps not only to clarify the history of that experience but also clearly identify many of the pitfalls which organizations may face. It is extremely unfortunate that as social workers we are unable to explain our positions to each other well enough that some mutually agreed upon basis of action can be arrived at. The article demonstrates clearly how ludicrous we must appear to lay groups.

Our association has been working on various proposals of legal regulation for some time and I believe this article a very timely supplement to the committee's work. I only hope that we will have the fortitude to keep on working the way the group in California has and I wish to express my thanks to the authors for making their experiences available to us.

PHILIP R. JOHNSTON

Chairman, Joint Committee of New York State Chapters, NASW
Delmar, New York

COUNCILS AND CHESTS—JOINT OR SEPARATE?

Community organization is a teamwork proposition, and will operate successfully only as such. This applies to the varied agencies embraced by community organization activities, to the working together of professional staff and lay leaders, and, also, to the close working relationship of councils and funds or chests. Because of this, and because Marion Hunt of Waterbury, Connecticut, might be considered by the reader to be speaking for the council field, I am prompted to reply to the statement in the October 1960 issue. . . .

If Miss Hunt had meant only that councils should have a separate board of directors and/or staff, I would not contest her point of view. That depends largely upon the make-up of those boards, the ability of the community to secure trained staff, and the personality of the community itself—more likely advisable in larger communities. (Actually the trend is the opposite—more cities are finding it more satisfactory to have a unilateral administration with departments of equal status, of planning, fund raising, public relations, budgeting, and perhaps others.) However, she appears to champion separate staff, board, physical quarters and independent financing. . . .

A close working relationship and financing of council and chest need be no deterrent to public agencies of the council. In fact in Lincoln, of our unduplicated count of 281 staff and laymen on our active committees, approximately 80 percent of these represent non-chest agencies, representing the Health Department, public welfare, national voluntary agencies, Veterans Administration, school, juvenile court and many others.

It is only logical that a fund-raising agency must rely on its "planning arm"—the council—which is in a position to give undivided attention to fact gathering and other study and consideration. Likewise the council must be knowledgeable concerning the total financial picture—and can gain this concerning chest-supported agencies only by working as a "partner" *with* the chest or fund.

This joint approach is the most salable to the public to whom we must feel responsible, and the most efficient, and fear of it can only represent insecurity. Of course, good leadership, both professional and lay, is the key to successful cooperative effort.

HAROLD F. BAKER

Lincoln, Nebraska

THE EDITORS REGRET . . . .

. . . . the inadvertent omission of place of delivery of Milton Wittman's article "Preventive Social Work: A Goal for Practice and Education" in the January 1961 issue of SOCIAL WORK. It was originally presented on May 2, 1960, at the annual institute for field instructors at the Fordham University School of Social Service, New York, N.Y.